

**Golden Valley Memorial Hospital**  
1600 North Second \* Clinton, Missouri 64735-1197\* (660) 885-5511  
**Student Athlete Evaluation Consent**

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES.** The undersigned voluntarily consents, either on his or her own behalf as a patient or on behalf of the patient named on the reverse, to hospital care encompassing diagnostic procedures and method treatment as ordered by the patient's attending physician or his or her designee. The undersigned is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantees have been made regarding the results of medical treatments or examinations performed in the hospital. The undersigned also consents to the study and retention or disposal of tissue or parts, which may be removed during procedure.
2. **LEGAL RELATIONSHIP BETWEEN THE HOSPITAL AND PHYSICIANS.** Physicians and surgeons furnishing services to the patient may be employees of the Hospital or Independent Practitioners. The patient is under the care and supervision of his or her physician, employed or independent and it is the responsibility of the Hospital and the Nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician to obtain the patient's informed consent, when required, to medical and surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered the patient under general and special instructions of the physician.
3. **FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS.** The undersigned authorizes payment directly to Golden Valley Memorial Hospital for hospital benefits otherwise payable to the patient or his or her guarantor. The undersigned agrees that he or she is financially responsible for timely payment of charges not paid under this assignment, and acknowledges that, even if an insurance claim is pending, he or she will receive a monthly statement from the hospital while the account has an outstanding balance.

The hospital contracts with several insurance company plans and payor networks to provide services to their members at negotiated rates. A list of these contracts is available in the hospital business office. The hospital has no contract, express or implied, with any plan or network not shown on the list. If the patient is a member of a plan or network, which does not appear on the list, the hospital will still bill the patient's plan as a courtesy. In that case, however, the undersigned agrees that he or she is individually obligated to pay the full charges for hospital services not paid by the patient's plan.

The undersigned understands that the hospital cannot accept responsibility for collecting on or negotiating a settlement for a disputed claim. Should the account be referred to an attorney for collections, the undersigned will pay reasonable attorney's fees and collections expenses.

If the charges for hospital services are covered under a workers compensation program, the undersigned acknowledges that the hospital has asked for the name and billing address of the workers compensation insurance carrier, and is aware that the hospital must have this information to receive payment for a workers compensation claim.

In the event there are excess proceeds or monies remaining or credited to this account after the payment in full the services rendered for the hospitalization, the undersigned hereby authorizes the hospital, at its sole discretion, to apply said excess to any of the undersigned's outstanding accounts with the hospital for services rendered of whatever nature or whenever incurred.

4. **RELEASE OF INFORMATION.** The undersigned agrees that to the extent necessary to determine coverage, eligibility, to pre-authorize services and/or to obtain payment the hospital may disclose portions of the patient's medical records to any governmental program, insurance company or third-party payor which is or may be liable for all or any portion of the hospital's charges. Special permission will be obtained to release this information when the patient is being treated for psychiatric illness, alcohol or drug abuse.
5. **PERSONAL VALUABLES.** The undersigned is aware that the hospital maintains a secure location for the safekeeping of money and valuables and the hospital shall not be liable for the loss or damage to any money, jewelry, documents or other articles of unusual value and small size unless placed therein. The liability of the hospital for loss of any personal property which is deposited with hospital for safekeeping is limited to three hundred dollars (\$300.00) unless a written receipt for a greater amount has been obtained by the patient from the hospital.
6. **AUTHORIZED REPRESENTATIVE.** The undersigned authorizes the hospital at its election but without obligation, to represent the patient regarding any application and appeal for eligibility and benefits related to Medicare, Medicaid, Social Security Administration or other governmental programs providing benefits relating to services rendered at the hospital.
7. **MEDICARE RECIPIENTS.** This paragraph applies to those patients eligible for benefits under the Medicare Program. The undersigned certifies that the information given in applying for payment under Title XIII of the Social Security Act is correct and requests that payment of authorized benefits be made directly to the hospital. The undersigned also acknowledges receipt of "An Important Message from Medicare", contained in the admission packet and the answering of Medicare Secondary Payer questions to the best of their knowledge.
8. **CHAMPUS RECIPIENTS.** The undersigned acknowledges receipt of "An Important Message from Champus", contained in the admission packet.

The undersigned certifies that he/she has read the forgoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

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Parent/Guardian Signature      Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Student Athlete Signature      Date

Authorized Signature