SPRINGHILL MEMORIAL HOSPITAL

CONSENT FOR SERVICES

The undersigned consent for Springhill Memorial Hospital (SMH), its authorized representatives, and its independent Physician Contractors, to write, Springhill Emergency Physicians, P.C., Springhill Diagnostic Radiologists, P.C., Coastal Anesthesia, Anesthesia and Pain Management, P.C., and Pathology Laboratory Associates, P.A. and the patients physicians to provide appropriate medical services including diagnostic and radiologic procedures, administration of medicines, and other treatment and hospital care considered advisable or necessary by the patient's treating physicians. The Independent Physician Contractors and their allied health professionals, including radiologists, pathologists, ER physicians and anesthesiologists, are independent contractors with the patient and are not employees, agents or representatives of SMH.

Absent emergency or extraordinary circumstances, no medical or surgical procedures will be performed upon a patient unless the patient has had the opportunity to confer with a physician or other health professional. The patient has the right to consent or to refuse consent to any proposed procedure or plan of treatment.

CONSENT FOR RELEASE OF PRESCRIPTION MEDICAL INFORMATION

I consent to the disclosure of my prescription medical information by any health care provider, mental health provider, pharmacy, insurer, prescription benefits manager or the SureScripts network (or similar network) to Springhill Memorial Hospital including its medical record of any prescription medical information obtained pursuant to this consent. My consent includes the re-disclosure of prescription information including information received from a drug or alcohol treatment program. This consent is subject to my revocation at any time except to the extent it has already been acted on.

PERSONAL PROPERTY AND VALUABLES

Personal property and valuables should be given to family members or to the cashier.

I understand that Springhill Memorial Hospital is not responsible for any personal property or valuables, such as money, credit cards, jewelry, luggage, clothing, dentures, eyeglasses, hearing aids, or other prosthetic devices that are not stored in the Cashiers' office.

I do not request storage of personal property and/or valuables. _____

I do request storage of personal property and/or valuables. _____

FINANCIAL OBLIGATION

Inconsideration of the services to be provided by SMH and the Independent Physician Contractors, the undersigned jointly and severally, agree to pay all charges, deductible and/or co-insurance amounts determined not paid or allowable by health insurance payors. I/we agree to make payments according to the hospital's and/or Independent Physician Contractors' credit terms. In the event I/we should default in payment of any of the above charges than I/we agree to pay all reasonable costs of collection, including a reasonable attorney's fee as might be allowed by law, whether the account shall be referred to a collection agency or an attorney.

ASSIGNMENT OF BENEFITS

The undersigned assign payment of authorized insurance benefits otherwise payable to the policyholder, including Medicare, Medicaid and Campus benefits, directly to Springhill Memorial Hospital and the Independent Physician Contractors, or their authorized representatives, who provided services. I further assign to the physician(s) or his authorized representative(s) the benefits payable for physicians' services.

MEDICARE/MEDICAID applies _____

I certify that all information is correct which has been given to apply for payment under the Medicare and/or Medicaid programs. _____

I received a copy of the MEDICARE MESSAGE (Rights). My initials acknowledge that receipt. By initiating, the patient has not waived his rights to request a review by a Peer Review Organization. I understand that if a review is requested, the patient is not liable for any payment until the Peer Review Organization has made its final decision. _____

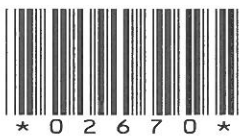
AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned authorize the hospital and the treating physicians, to furnish any medical and billing information about this account, including but not limited to the following:

(a) INSURANCE BILLING - Information requested by the insurance company, Medicare, Medicaid, Champus or other third party payors to support the claim submitted for payment of charges applicable to this account.

(b) MEDICAL NECESSITY AND APPROPRIATENESS OF SERVICES - Information requested by and utilization and/or Peer Review Organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services of the account or to determine the benefits for related services.

(c) MEDICAID BILLING - I hereby authorize the Alabama Medicaid Agency and/or my Primary Medical Provider to release any and all required information that may be needed by Springhill Memorial Hospital for billing purposes. This information maybe obtained for billing claims to the Alabama Medicaid Agency. Without the various information that is required by the Medicaid Agency we may not be able to file a claim on your behalf or obtain referral numbers, pre-certification or other information.



CONTINUE ON BACK

SPRINGHILL MEMORIAL HOSPITAL

This release allows disclosure about the treatment, diagnostic testing, or other medical information including psychiatric, alcohol, HIV, drug abuse, cancer registry treatment and followup and/or other confidential information. The recipients are prohibited from any re-disclosure of this information. Th eundersigned has the right to subsequently revoke this release. That revocation shall not pertain to information previously released. Information requested in good faith by any health care fecility or physician for facilitating continuing care and treatment is authorized.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERTSTAND ITS PURPOSES AND CONTENT.

Signature of Patient or atient's Representative

Relationship to Patient

Print Patient or Representative Name

Signature of Witness Full Name

Print Witness Full Name

Date

REGISTRATION FORM

Patient Name
(First)_____(MI)_____(Last)_____

Address_____City_____

Zip_____ Home # _____Work#_____

Cell#_____

Date of Birth_____/_____/_____ Age_____

Social Security #_____

Sex: Male_____ Female_____ Marital Status:_____

Date of injury_____ and/or Date of surgery:_____

Was this related to an _____auto accident_____work injury _____sports injury

Please list the name of a nearest relative or someone we can contact in case of emergency:

Name_____Relationship_____

Phone number_____

If employed:

Current
employer_____Address_____

Phone
number_____Occupation_____

If retired:

Date of retirement_____

If Under 18:

Name of Guardian (s)_____ Cell #_____

_____Cell #_____

PLEASE DO NOT LEAVE YOUR CHILD HERE WHILE THEY ARE RECEIVING TREATMENT UNLESS IT IS APPROVED BY THE THERAPIST.

FUNCTIONAL TRIGGER WORKSHEET

Have you experienced a functional decline in any of the following categories resulting **directly** from **this** medical event?

FEEDING	No change	_____
	Need help (dropping items, holding utensils, hand to mouth control, etc)	_____
	Unable	_____
BATHING	No change (bath/shower)	_____
	Need help; can do about ½ unaided	_____
	Unable	_____
GROOMING	No change (face, teeth, hair, etc.)	_____
	Need help; can do about ½ unaided	_____
	Unable	_____
DRESSING (UPPER AND LOWER)	No change (includes buttons, zips, laces)	_____
	Need help, can do about ½ unaided	_____
	Unable	_____
TOILET USE	No change (on & off, dressing, personal Hygiene)	_____
	Need help, but can do something alone	_____
	Unable	_____
HOMEMAKING	No change (sweeping, reaching shelves, Bending, cooking)	_____
	Need help, but can do some alone	_____
	Unable	_____
HANDWRITING, READING	No change	_____
	Need help	_____
	Unable	_____

Do you want to be able to improve in any of the above areas?

PATIENT INFORMATION SHEET

Name:_____ DOB:_____

1. List any allergies you have to medication:

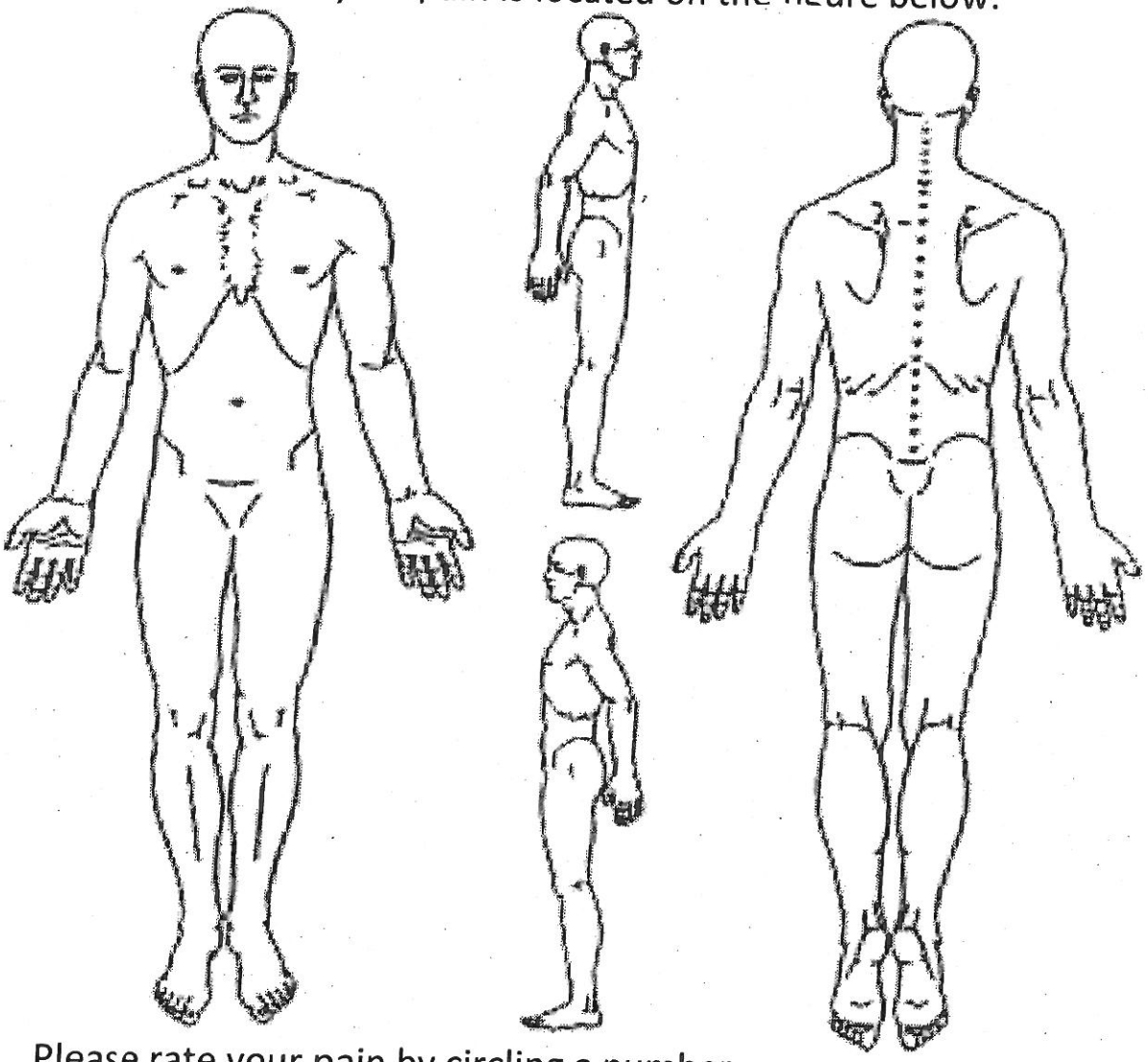
2. List any medical problems you may have other than what you are here for:

3. Are you currently taking medication? Please list:

4. List any surgeries you have had in the past 5 years:

INSTRUCTIONS

Indicate where your pain is located on the figure below.



Please rate your pain by circling a number.

No Pain	Minimal	Moderate	Intense	Emergency
0	1 2 3	4 5 6	7 8 9	10

Springhill Memorial Hospital
3719 Dauphin Street
Mobile, AL 36608

Notice of Privacy Practices Acknowledgement
Revised: 7/1/04

I acknowledge that Springhill Memorial Hospital has made their Notice of Privacy Practices available to me.

Signature of Patient or Patient's Representative	Relationship to Patient
Date	Witness

Release Date: 7/1/04

SMH 23405