AGREEMENT FOR ASSIGNMENT OF INSURANCE BENEFITS

DEFINITIONS: All references in this consent form to "SCL Health" shall mean Sisters of Charity of Leavenworth Health System, Inc. and any and all of its controlled affiliates, including but not limited to its hospitals and clinics.

SECTION 1. ASSIGNMENT OF INSURANCE BENEFITS

This "Assignment of Insurance Benefits" allows SCL Health to bill your insurance company and for your insurance company to pay SCL Health as explained below: I for myself or for the patient (referred to as "I" or "Patient" or "me" or "my") give my permission for my insurance company(ies) to make payment directly to SCL HEALTH of inpatient and outpatient hospital and/or clinic services and related benefits, including major medical, otherwise payable to me. I certify that information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is true and correct to the best of my knowledge. I irrevocably assign to SCL HEALTH all right, title and interest in compensation or payment received or to be received from any source as a result of injuries sustained by me, and any person or corporation having notice of this assignment is hereby authorized and directed to pay directly to SCL HEALTH the amount of any indebtedness due SCL HEALTH for services provided by them to me. Additionally, I understand and agree that each Clinical group, to include certain SCL Health affiliates, or individual health care providers/practitioner thereof (referred to as the "Clinicians" or "health care providers") who provide professional services to me will bill and collect for their own professional services separate and apart from SCL HEALTH facility charges, but subject to the authorizations granted by me in accordance with this agreement, and I hereby authorize and request that insurance benefits for medical and professional services, otherwise payable to me, be assigned and paid directly to the Clinicians who rendered care to me. In the case of Medicare benefits, payment may not exceed the maximum allowable charge as determined by the Medicare carrier.

SECTION 2. STATEMENT OF FINANCIAL RESPONSIBILITY/TRANSFER OF CREDITS

This "Statement of Financial Responsibility/Transfer of Credits" is your promise to pay for any services not covered by your insurance company as explained below: I understand the services provided by SCL HEALTH and/or the Clinicians, today or in the future, may or may not be paid for by my health plan or health insurance. If my health plan/insurance deems any or all of these services are not covered and/or not medically necessary for any reason, then I understand that I am personally financially responsible for payment of those services and/or supplies provided to me and I agree to be the guarantor of payment for all services rendered to me in accordance with the regular charges and terms of SCL HEALTH and the Clinicians for such services. If this agreement is executed by a spouse or a financial guarantor of the Patient, the spouse or the financial guarantor shall be jointly and severally liable with me (meaning that both I and my spouse or financial guarantor will be obligated to pay the Clinicians and SCL HEALTH), and by me or my personal representative signing this agreement, those persons, together with me, do hereby promise to pay the Clinicians and SCL HEALTH all amounts due and owing for my account. Although the Clinicians and/or SCL HEALTH may file insurance claims as a courtesy, I understand that the Clinicians and/or SCL HEALTH cannot accept responsibility for collecting insurance payments or for negotiating a disputed claim, unless a contractual or legal obligation of the Clinicians and/or SCL HEALTH provides otherwise. Insurance reimbursement is a contract between me and my insurance carrier and an insurance company's Usual, Customary and Reasonable ("UCR") allowables or fee schedules are generally established without regard to the Clinicians' or SCL HEALTH's charges except in circumstances where the Clinicians and/or SCL HEALTH have a contractual agreement(s) with a health plan that prohibits such collection of payment from me and/or the subscriber. Should this account be referred to an attorney or collection agency, reasonable attorney's fees and/or collection expenses shall be payable by me in addition to any other amounts due. I hereby authorize the transfer of monies paid to SCL HEALTH by me or on my behalf and otherwise refundable to me, to be transferred to settle any indebtedness I owe to SCL HEALTH, for which I am responsible.

SECTION 3. PERMISSION TO BE CONTACTED BY DIFFERENT METHODS TO INCLUDE MY CELL PHONE

This "Permission to be Contacted by Different Methods to Include My Cell Phone" allows SCL Health to contact me and how it will contact me as explained below: By signing below and as part of my admission, treatment, evaluation, diagnosis, prescriptions, testing and/or lab results ("Services"), I expressly understand, consent and agree that SCL HEALTH and its hospitals/clinics, affiliated physician groups, as well as any and all of their affiliates, sub-contractors, agents, labs, vendors, assigns, representatives, successors and debt collectors ("the Calling Parties") may call or contact me for any reason related to the provision of the above Services using an automatic telephone dialing systems, predictive dialer, artificial or prerecorded voice and/or prerecorded messages, via any electronic mail addresses through individual or automatically generated electronic mail, and via text messaging through individual and automatically generated text messages at (a) any cellular telephone number or land-line number or electronic mail address that I or any person acting on my behalf may provide to the Calling Parties at the time of, during, or after any hospital/clinic admission, follow up visit, telephone call, payment or address update, or (b) at any telephone number the Calling Parties can find me at in the future as a result of skip-tracing, call capture, caller ID technology, internet search engines, White Pages and/or similar search methods. This consent applies to all healthcare providers covered under this agreement. If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by emailing you at DoNotCall@sclhs.net , mailing it to SCL Health, Attn: Do Not Call-Self Pay, 500 Eldorado Blvd., Broomfield, CO 80021 or calling the toll free line at 1-866-665-2636. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or prerecorded messages.

I AGREE TO BE BOUND BY SECTIONS 1, 2, AND 3.

Date	Time	Signature of Policy Holder (usually the patient) or Authorized Representative
Date	Time	Signature of Witness

SCL Health

ON154

Agreement For Assignment Of Insurance Benefits

EH-FR-TX-0679-0418-SCLHS

PATIENT INFORMATION

Place label here.
Scanning does NOT work if label is outside this guide.