St. Elizabeth Healthcare
Covington/Edgewood/Grant Co., Kentucky

Patient: _____

Account No.:_____

Date: _____

ASSIGNMENT OF BENEFITS

1. I hereby authorize, request and direct my health/hospitalization insurance company or third party payor of record to pay directly to St. Elizabeth Medical Center, Covington/Edgewood/Grant Co., Kentucky, and any of my other medical providers, the hospital benefits or any other benefits payable under the terms of my health insurance policy or plan.

2. I further authorize St. Elizabeth Medical Center or any of my treating physicians to release medical, psychiatric, psychological, and/or other information to the Medical Center's legal counsel, third-party payers, benefit administrators, guarantors and/or other persons as necessary for them to verify benefits, to determine the necessity and appropriateness of my hospital stay or services, to authorize medical services to be received, process claims for benefits, and/or to represent me in a third party payor's hearing and/or appeal process regarding payment for hospital expenses, including, but not limited to, Medicaid's hearing and appeals process.

STATEMENT OF FINANCIAL RESPONSIBILITY

3. I understand that hospital and medical bills are due and payable upon discharge. By signing below, I accept and acknowledge financial responsibility to St. Elizabeth Medical Center and other medical providers, including but not limited to, my treating physician, surgeon, anesthesiologist, radiologist and Durable Medical Equipment (DME) provider, for payment of their fees for services rendered to the above patient and not paid timely by health insurance or plan. I hereby agree and promise to pay St. Elizabeth Medical Center's fees on or before the patient's discharge date unless upon admission I make other arrangements in writing with a Financial Counselor at St. Elizabeth Medical Center.

4. REGIMEN OF TREATMENT:
When St. Elizabeth Medical Center provides services to the above patient through a regular, on-going course of treatment on an outpatient basis (a Regimen of Treatment), a Series Account will be established, which account will bear different account numbers each month, but which will reflect services rendered for the same primary diagnosis with no change in payor. By signing below, I accept and acknowledge financial responsibility to St. Elizabeth Medical Center and other medical providers as set out in paragraph 3 above for payment of fees for services to the above patient under a Regimen of Treatment for up to one year but ending on the last day of the calendar year, provided the fees are not paid timely by a health insurance policy or plan. I hereby agree and promise to pay St. Elizabeth Medical Center's fees related to the Regimen of Treatment on the date of each said treatment, unless I make other arrangements in writing with a financial counselor at St. Elizabeth Medical Center.

MEDICARE NOTICE OF NON-COVERAGE

5. MEDICARE NOTICE OF NON-COVERAGE: Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. Self administered drugs to outpatients are not covered under the law. I have been notified that if I receive drugs that are able to be self administered while an outpatient of the Medical Center, Medicare will not cover payment for such items. I agree to be personally responsible for payment.

I, the undersigned, understand that by providing a cellular telephone number to SEMC, I hereby freely, voluntarily, and expressly authorize, agree, and consent to receive telephone calls from SEMC and/or it's third party dept collectors to said cellular telephone, which calls may be placed by means of an automatic telephone dialing system or an artificial or pre-recorded voice. This authorization specifically pertains to services provided this date forward and in the past.

X _____ _____

Signature of Policyholder/ Insured/ Responsible Party — Date

_____ _____

Relationship to Patient — Witness