GENESIS HEALTHCARE ASSOCIATES, P.C

Registration Agreement

Consent To Treat

I. **CONSENT FOR TREATMENT:** I consent to such routine diagnostic and treatment procedures/examinations and laboratory procedures considered reasonably necessary for the care and treatment of my condition during my care at Genesis Healthcare Associates. I understand that diagnostic and treatment procedures involving material risks will be explained to me and that I will have the opportunity to ask questions concerning the associated risks, alternatives, and prognosis before allowing the procedures to be performed.

II. **INDEPENDENT CONTRACTORS:** I understand that some of the health care professionals providing care, treatment and services at Genesis Healthcare may be independent contractors, and not agents or employees of Genesis Healthcare. Independent contractors are responsible for their own actions and Genesis Healthcare shall not be liable for the acts or omissions of any such independent contractor.

III. **ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT AND APPOINTMENT OF REPRESENTATIVE:** If I am entitled to benefits under the Medicare program, the Medicaid program, or any insurance policy or other health benefit plan (covering me or anyone legally responsible for me), in consideration for services provided to me by Genesis Healthcare, I assign, transfer, and convey to Genesis Healthcare the benefits payable under such program, policy, or plan for services provided to me. I authorize payment of benefits directly to Genesis Healthcare, with such benefits to be applied to my bill. **I understand and acknowledge that this assignment does not relieve me of financial responsibility for charges incurred by me or anyone on my behalf, and I hereby acknowledge responsibility for and agree to pay charges not paid under this assignment, including any coinsurance amounts and deductibles and any charges for services deemed to be non- covered, not pre-certified, or not preauthorized by my insurance plan.**

If my health care benefits are provided under a self-funded plan under the Employee Retirement Income Security Act (ERISA), in order to assist me in obtaining my benefits, I authorize and appoint Genesis Healthcare to act as my representative, when Genesis Healthcare consents in writing to so act, in appealing any adverse benefit determination and to receive notices on my behalf with respect to the same. I agree that I will comply with procedures established by my benefit plan relating to this authorization, if any.

IV. **CONSENT FOR DISCLOSURE OF INFORMATION:** I understand that Genesis Healthcare is permitted to disclose protected health information about me for purposes of payment, my continued care or treatment, and healthcare operations. If my protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS confidential information), drug or alcohol abuse and/or mental illness, I hereby consent to the disclosure of this information by Genesis Healthcare only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I understand this consent permits release of the identified information to any insurance company, healthcare plan or any other person or entity financially responsible for my treatment if necessary or purposes related to filing a claim for payment, or, if I am being evaluated for the purposes of determining eligibility, and to my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, government or private agency which may provide medical, mental health, rehabilitation, social or related services to me during or upon my transfer from Genesis Healthcare.

I understand my consent to disclosure of information related to treatment of any infectious disease (including AIDS confidential information) drug or alcohol abuse, or mental illness is valid until all bills related to my treatment have been paid and utilization and/or quality assessment have been completed. I further understand
I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

AGREEMENT TO ALTERNATIVE DISPUTE RESOLUTION: I agree that any claim or dispute arising out of or related to the provision of health care services to me by Genesis Healthcare, or its employees or agents, except as otherwise provided herein, shall be resolved by final or binding arbitration. I agree that this provision is governed by the terms of the Federal Arbitration Act. I understand and agree that this agreement includes and encompasses

any claims arising out of or relating to health care services which shall be provided to me by Genesis Healthcare Associates, provided, however, that this agreement does not include and encompass any claim or dispute by either party arising out of or related to the billing or payment for health care services. I understand and agree that by agreeing to arbitrate, I am waiving my right to a jury trial (if otherwise available). I understand that this agreement is also binding on an individual or entity claiming by or through me or on my behalf. I understand that this agreement is voluntary and is not a precondition to receiving health care services. The arbitration of any claim or dispute hereunder shall be conducted in the State of Georgia. I understand that I have the right to revoke this agreement no later than ten (10) days following signature and that, if I choose to revoke, I must request and execute a revocation form within this time period.

NOTE: If the individual signing this agreement is doing so on behalf of his or her minor child or any other person for whom he or she is legally responsible, the signature below affirms that he or she has the authority or obligation to contract with Genesis Healthcare Associates for the provision of health care services to that minor child or other person, and this his or her execution of this agreement is in furtherance of that authority or obligation.

DATE _____ _____

PATIENT, PARENT, GUARDIAN
OR AUTHORIZED REPRESENTATIVE

V. PHOTOGRAPHS, VIDEOTAPES, AND RECORDINGS: I understand that the physicians or staff at Genesis Healthcare Associates may request to take photographs, videotapes, or other recordings of me for purposes of ensuring proper patient identification or for medical documentation, care or treatment purposes, and I consent to being photographed, videotaped, or recorded for these purposes. I further acknowledge that such photographs, videotapes, recordings, and related information may be used for internal operations purposes of Genesis Healthcare Associates, including but not limited to medical education, training programs, quality assessment and improvement activities, outcomes evaluation, case management, and related functions that do not include treatment. I understand that such photographs, videotapes and recordings will be maintained in a secure manner and will not be disclosed for external use, except upon written authorization from me or my authorized representative or as required or permitted by law.

VI. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received Genesis Healthcare's Notice of Privacy Practices. -_____(*please initial)*

The date of this Registration Agreement is (*insert today's date*) _____

_____ _____

Witness Signature of Patient or Patient's Representative

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Relationship of Representative to Patient