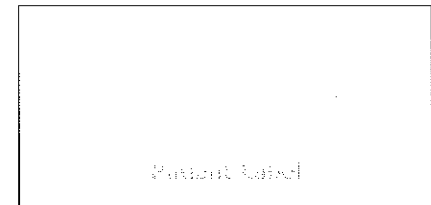


One team united in caring™
KNOX COMMUNITY HOSPITAL
1330 Coshocton Road • Mount Vernon, Ohio 43050



This consent form applies to Knox Affiliated Health Services operating as a clinically integrated health care arrangement composed of Knox Community Hospital and Physicians. The members of this clinically integrated health care arrangement work and practice at Knox Community Hospital and physician practices owned by Knox Community Hospital (collectively the "Hospital"). All of the entities owned or operated by Hospital and all physicians affiliated with the Hospital will share the medical information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

CONSENT FOR MEDICAL CARE: I consent to hospital and/or emergency care, which may include routine diagnostic procedures and such medical treatment as the named attending physicians or others of the Hospital's medical staff consider to be necessary. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as the result of examination or treatment. I understand that it is customary that no substantial procedures are performed upon a patient unless and until he or she has had an opportunity to discuss them with the physician or other health professional to the patient's satisfaction. Each patient has the right to consent, or to refuse consent, to any proposed procedure or therapeutic course. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent. Any tissue or parts surgically removed may be disposed of by the Hospital in accordance with the accustomed practice.

I consent to and understand that if I am a patient in the Intensive Care Unit, Step Down Unit, Sleep Lab, or Emergency Department, I may be video monitored.

I understand that some physicians on the staff of the Hospital are not employees or agents of the hospital but are independent contractors who have been granted the privileges of using the hospital's facilities for the care and treatment of their patients. Further, I realize that among those who attend patients at the Hospital are medical nursing and other health care personnel in training who, unless requested otherwise, may be present during patient care as a part of their education.

I acknowledge that the Hospital may contract with Knox Diagnostic Imaging Center ("KDIC") to provide certain diagnostic imaging procedures that may be part of my medical care. I acknowledge that the physician ordering diagnostic imaging procedures as part of my medical care may have an ownership interest in the Center. I consent to the ordering and performance of diagnostic imaging procedures by a physician who may have an ownership interest in the KDIC and KDIC.

ASSIGNMENT OF INSURANCE BENEFITS: I understand that charges are made for Hospital services provided by the Hospital and its Affiliated Physicians. I also understand that, if these charges are covered by insurance or other third party reimbursement of any type, I hereby authorize assignment of these benefits to Hospital and its Affiliated Physicians. However, it is nevertheless my personal obligation to pay for all charges. In addition, I understand that I may be responsible for separate billing of physician charges.

PERSONAL VALUABLES: I understand and agree that the Hospital shall not be liable for the loss or damage to any personal property.

The undersigned certifies that he/she has read the foregoing and is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

Date Signature of Patient/Parent/Guardian/Other Date

Witness Relationship if other than patient

NOTICE OF PRIVACY PRACTICES: I understand and have been provided a copy of Knox Community Hospital's "Notice of Privacy Practices", which describes how Knox Community Hospital may use and disclose my personal health and medical information. I understand I have the right to review Knox Community Hospital's "Notice of Privacy Practices" before signing this consent. I understand that Knox Community Hospital has the right to change its Notice of Privacy Practices at any time. If the Notice of Privacy Practices is changed, I may obtain a revised copy from Knox Community Hospital.

I have been provided a copy of Knox Community Hospital's "Notice of Privacy Practices" _____ Date _____

I understand that I may revoke this consent, in writing, except to the extent that Knox Community Hospital has already taken action in reliance on my consent.