AUTHORIZATION FOR MEDICAL CARE IN THE EMERGENCY DEPARTMENT

(Fill out in the absence of label)

Hospital Name _____

Full Name: _____

Date of birth: __/__/__ Age: _____ Gender: _____ Bed: _____

Admission Date: __/__/__ Time: _____ Registration: _____

Chief Medical Officer: _____ CRM: _____

The patient and / or representative undersigned authorizes hereby, the delivery of care to the patient in the Emergency Department, under the provisions specified below:

a. Hospital care will be provided to the patient, in compliance with good technique, respecting the organization's internal criteria and through specialized staff, being authorized, as of now, to perform all clinical or surgical procedures indicated, carry out tests and additional diagnostic methods, administer medication and perform, ultimately, all actions necessary to deliver perfect patient care.

b. The patient / representative states awareness of the rules established by this organization regarding the stay of companions during care, which must be respected, with the exception of minors, who have the right to be accompanied by a parent or representative. The care delivery to unaccompanied minors will be monitored and reported immediately to the minor's parents and / or representative. Elderly patients, aged over 60 years are entitled to preferential treatment, in compliance with urgency / emergency situations and shall be guaranteed the right to a companion.

c. The treatment (s), clinical care, medication(s) or procedure(s) proposed, whether tests and/or surgery which may be performed will have its benefits, risks, potential complications and alternatives explained during medical care. The patient /representative is given the opportunity to ask questions and receive answers in order to give free and informed consent.

d. Hospital expenses will be paid at the time of its closure.

e. The patient, if health insurance beneficiary, states that he/she has received proper documentation (agreement) from the Insurance Provider, which sets forth the scope offered, as well as limitations and exclusions contained in the contract, being aware that the mere provision of authorization form for admission does not guarantee full coverage of expenses by the health insurance provider.

f. This organization has no involvement in the contractual relationship set between the patient and the Health Care Insurance Provider and if there is a payment refusal by the latter, whether total or partial, the hospital reserves the right to collect the amount due according to the hospital's pricing table, which is available for consultation in the Administration Department.

g. If the service provided by the hospital is for any reason not paid by the Health Care Insurance Provider, it shall be subject to arrears penalty equivalent to 2% (2 percent) of the delayed payment price, interest for late payment of 1% per month on any delay of payment, as well as update by the IGP-M of Getulio Vargas Foundation until the effective date of settlement.

h. The parties agree that any dispute arising out of the delivery of hospital medical services now set will be processed before the Forum determined by the applicable law.

PATIENT/REPRESENTATIVE:

I state that I have read and I understand and agree with all the information described on this statement.

Location _____ Date Month _____ Year 20____ Time: _____

Legible name: _____ Signature: _____

Representative relatedness to the patient: _____ CPF (ID number): _____

WITNESS

Legible name: _____ Signature: _____