FORM 8-3

Assignment of Proceeds of Claim

In consideration of the *(hospital name)* _____ furnishing services to the undersigned or *(patient name)* _____, I hereby assign to the above-named hospital such sum of money sufficient in amount to cover the entire amount of charges for such services which I, or the above-named patient, may receive, either as a result of court action or by reason of settlement of any action instituted by me, or the above-named patient, or on my or the above-named patient's behalf, arising out of the injuries which caused my hospitalization or that of my child, ward, or conservatee, in said hospital.

I hereby authorize and instruct my attorney to pay directly to the hospital out of any proceeds received as a settlement or by reason of a judgment the entire amount of the hospital bill incurred by me in connection with the care and treatment of me or the above-named patient for injuries received.

I fully understand that I am directly and fully responsible to said hospital for all bills submitted by it for services rendered to me or the above-named patient, and that this agreement is made solely for said hospital's additional protection and in consideration of its awaiting payment. I further understand that such payment is not contingent on any settlement or judgment by which I or the above-named patient may eventually recover said sum.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

The undersigned, being attorney of record for the above-named patient, or his/her legal representative, does hereby agree to observe all of the terms of the above, and agrees to withhold such sum from any settlement or judgment, and to pay over such funds as may be necessary to discharge the obligation to the hospital.

I further agree that in the event that my client, the above-named patient or his/her legal representative, secures other counsel in connection with any action instituted by him/her or the above-named patient on account of the injuries for which he/she or the above-named patient receives hospital services, I shall inform such other counsel of this agreement, and solicit his/her assent thereto.

Date: _____ Time: _____ AM / PM

Signature: _____
(attorney)

Print name: _____
(attorney)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)

FORM 8-3S

Asignacion de los Reditos de una Reclamación

En consideración de los servicios prestados por *(nombre del hospital)* _____ al suscrito o a *(nombre del paciente)* _____, por medio de la presente cedo al hospital arriba mencionado la suma de dinero suficiente para cubrir el monto total de los costos de dichos servicios que sean administrados a mí o al paciente antes nombrado, sin importar si esta suma procede de una demanda judical o por motivo de una conciliación resultante de un proceso iniciado por mí, o por el paciente antes nombrado, o en nombre mío o del paciente antes nombrado, como resultado de las lesiones que ocasionaron la hospitalización mía o de mi hijo o hija, pupilo o pupila, o de la persona por quien soy conservador, en dicho hospital.

Por medio de la presente autorizo e instruyo a mi abogado a que pague directamente al hospital de los réditos recibidos de la conciliación o por motivo de un fallo el monto total de la cuenta de hospital contraída por mí en relación con la atención y el tratamiento administrados a mí o al paciente antes nombrado relacionados con las lesiones recibidas.

Comprendo plenamente que soy directa y plenamente responsable ante dicho hospital de todas las facturas sometidas por el hospital por los servicios que se me administraron a mí o al paciente antes nombrado, y que el presente acuerdo se contrae únicamente para la protección adicional del hospital mencionado y en consideración del pago anticipado. Además comprendo que dicho pago no depende de ninguna conciliación ni de ningún fallo mediante el cual yo o el paciente antes mencionado pudiéramos eventualmente recuperar dicha suma.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(representante legal)

The undersigned, being attorney of record for the above-named patient, or his/her legal representative, does hereby agree to observe all of the terms of the above, and agrees to withhold such sum from any settlement or judgment, and to pay over such funds as may be necessary to discharge the obligation to the hospital.

I further agree that in the event that my client, the above-named patient or his/her legal representative, secures other counsel in connection with any action instituted by him/her or the above-named patient on account of the injuries for which he/she or the above-named patient receives hospital services, I shall inform such other counsel of this agreement, and solicit his/her assent thereto.

Date: _____ Time: _____ AM / PM

Signature: _____
(attorney)

Print name: _____
(attorney)

NOTE: This form should include taglines as required by the Affordable Care Act.
(See www.calhospital.org/taglines, for detailed information.)