

Conditions of Admission

Consent to Medical and Surgical Procedures: The patient's signature on this form indicates his/her consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, which may include but are not limited to laboratory procedures, imaging examinations, medical or surgical treatment or procedures, anesthesia, or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon. A separate consent for specific treatment or services may need to be signed in addition to this form as required by hospital policy.

Legal Relationship between Hospital and Physician: All physicians and surgeons furnishing services to the patient, including, but not limited to radiologists, pathologists, anesthesiologists, hospitalists and emergency physicians, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the physician.

Disclosure of Physician Ownership: The physician who referred the patient to us may have an ownership interest in this hospital. A list of physicians who have an ownership interest in this hospital is available upon request.

Personal Valuables: The hospital is not liable for the loss of or damage to any money, jewelry, documents, and medications brought from home, or other personal items. The patient agrees to send such items home with family members. In a rare situation or emergency, the patient may notify the nurse of personal items to be deposited with the hospital for safekeeping. Such items will be receipted. The nurse will enlist the assistance of another hospital employee to witness the transfer. The receipt will be signed by the patient, the nurse and the witness.

Advance Directives: I understand that advance directives may include a Directive to Physicians and Family or Surrogate (Living Will), Medical Power of Attorney, Declaration of Mental Health Treatment or Out-of-Hospital DO NOT Resuscitate Order.

Please read and initial all applicable statements and circle the words "DO" or "DO NOT" where indicated.

- ____INITIAL 1. I **DO** have an executed Advance Directive in the form of one of the following, and have been requested to provide a copy to the hospital: Medical Power of Attorney, Directive to Physicians and Family or Surrogate (Living Will), Declaration of Mental Health Treatment, Out-of-Hospital Do No Resuscitate Order.
- ____INITIAL 2. I **DO** have an executed Advance Directive and have been requested to provide a copy to the hospital; however, I do not wish to provide a copy at this time.
- ____INITIAL 3. I **DO NOT** have an executed Advance Directive. The hospital has offered me information on Advance Directives which I **DO / DO NOT** wish to receive.

Assignment of Insurance Benefits: The undersigned authorizes, whether he/she signs as patient or duly authorized representative, direct payment to the hospital of any insurance benefits otherwise payable to or on behalf of the patient for this hospital visit. It is understood by the undersigned that he/she is financially responsible for charges not paid pursuant to this assignment.

Financial Agreement: The undersigned agrees, whether he/she signs as patient or duly authorized representative that, in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or collection agency, the undersigned may incur additional fees from any actions to collect the debt. All delinquent accounts shall bear interest at the maximum rate allowed by law.

Telephone Consumer Protection Act: The undersigned authorizes the Hospital and all clinical providers who have provided care to the patient, along with any billing services, collection agencies, attorneys, or other agents working on their behalf, to contact the patient on his or her cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.

Release of Information: The undersigned agrees that the Hospital may disclose his/her "protected health information" (PHI), in compliance with HIPAA Privacy provisions which may include medical records, to third parties including, but not limited to, health insurers, health care service plans, state and federal agencies, workers compensation carriers, manufacturers required by FDA to track medical devices, or his/her employer. This also includes appropriate release of and disclosure of medical records in compliance with HIPAA to his/her physicians and other health care providers when necessary for treatment and general health. While in the hospital or outpatient departments for treatment and care, the hospital/outpatient departments have permission to disclose pertinent PHI information to family members, friends or designated caregivers who may be present.



C O A



PATIENT LABEL

Medicare Certification, Authorization to Release Information, and Payment Request: The undersigned certifies that the information provided in applying for payment under Title XVII of the Social Security Act is correct. He/She authorizes any holder of medical or other information about him/her to release to the Social Security Administration or its intermediaries any information needed for this or a related Medicare claim. The undersigned requests that payment of authorized benefits be made on his/her behalf.

____ INITIAL **HIPAA Privacy Notice:** I acknowledge I have received the "Notice of Privacy Practices (HIPAA)" and have had the opportunity to review its content.

____ INITIAL **Patient's Rights and Responsibilities:** I acknowledge I have received the "Patient's Rights and Responsibilities."

____ INITIAL **Understanding Physician Billing:** I acknowledge that a physician or other health care provider who provides services to me during my visit may not be participating in the same plan as the hospital. I will be responsible for paying these health care providers separately, subject to the terms of my health insurance plan, if any.

____ INITIAL **Financial Assistance Policy:** I acknowledge I have received the "Financial Assistance Policy."

____ INITIAL **Disclosure of Physician Ownership:** I acknowledge I have received the "Notice to Patient: Disclosure of Ownership."

____ INITIAL **Patient Notification of Data Collection:** I acknowledge I have received the "Patient Notification of Data Collection."

____ INITIAL **Notice of Patient Visitation Rights:** I acknowledge I have received the "Notice of Patient Visitation Rights."

____ INITIAL **Notification of Family Member/Representative/Physician:** I **DO / DO NOT** authorize notification of another party.

If notification is desired, list names and contact information:

- Name: _____ Contact Info: _____
- Name: _____ Contact Info: _____

I certify that I have read this document, am the patient or duly authorized representative and accept the terms herein.

Signature	Time: _____	Date: _____
am/pm		
If signed by other than patient, indicate relationship:		

Witness:	Time: _____	Date: _____
am/pm		

For Staff Use Only

The above named person was provided with a copy of the "Notice of Privacy Practices." A good faith effort was made to obtain a written acknowledgement of his/her receipt of the Notice, but such acknowledgement could not be obtained because:

Person refused to sign

Person was unable to sign

The patient had a medical emergency and an attempt to obtain the acknowledgement will be made at the next available opportunity

Other reason (*specify*): _____

Notification of Family Member/Representative/Physician:

Call was made to family member/representative/physician identified above.

Contact 1: Left message Spoke to: _____ Time: _____ am/pm Date: _____

Contact 2: Left message Spoke to: _____ Time: _____ am/pm Date: _____

Signature of Staff:	Time: _____	Date: _____
am/pm		

