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.

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 Independent Legal Entity**: I acknowledge I have received the "Notice to Patient: Disclosure of Independent Legal Entity."

_____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:________________________

_____INITIAL **Photography and Filming for Purposes of Diagnosis, Identification and Treatment:** I consent to the taking of pictures for purposes of identification and treatment of my condition or disease, and the inclusion of such pictures in my medical record. In addition, I consent to the use of such pictures for medical, scientific, or educational purposes, providing my identity is not revealed by the pictures or descriptive texts accompanying the pictures.

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

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

Witness:	Time: am/pm	Date:

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: am/pm	Date: