Physicians Care Surgical Hospital

CONDITIONS OF ADMISSION TO HOSPITAL

1. **Consent to Medical and Surgical Procedures:** The undersigned consents 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, x-ray 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.

2. **Nursing Care:** This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient needs more intensive nursing care. If the patient's condition requires the service of a special duty nurse, it is agreed that such an arrangement will be made by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

3. **Legal Relationship Between Hospital and Physician:** All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, 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.

4. **Release of Information:** I agree that the hospital may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records to any third party payers, 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 my employer. This includes appropriate release of and disclosure of my medical records in compliance with privacy provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the hospital for treatment and general care, the hospital has permission to disclose pertinent information to family members, friends or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclose. Special permission is needed to release this information if the patient is treated for alcohol or drug abuse.

5. **Advance Directives:**

I understand that advance directives may include living wills or other probate arrangements, durable powers of attorney or appointment of a "healthcare surrogate".

Please read and initial all applicable statements and Circle the words [**DO** or **DO NOT**]:

a. I DO have an executed Advance Directive & have been requested to supply a copy to the hospital. INITIAL _____
A temporary suspension of the Advance Directive/DNR occurs during the surgical invasive procedure. INITIAL _____

b. I DO NOT have an executed Advance Directive. The hospital has offered me information on Advance Directives which I [**DO** or **DO NOT**] wish to receive. INITIAL _____

c. I DO have an executed Durable Power of Attorney for Healthcare Decisions. INITIAL_____

d. I DO NOT have an executed Durable Power of Attorney for Healthcare Decisions. The hospital has offered me information on Durable Power of Attorney for Healthcare Decisions which I [**DO** or **DO NOT**] wish to receive. INITIAL _____

6. **Personal Valuables:** The hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats, and fur garments or other articles of unusual value and small size. The hospital shall not be liable for loss or damage to any other personal property. The patient agrees to send valuables home with family members or in a rare situation or emergency the patient will notify their nurse that they need their valuables deposited with the hospital for safekeeping at which time valuables will be itemized, patient will sign valuable receipt along with two hospital employees.

7. **Financial Agreement:** The undersigned agrees, whether he/she signs as agent or as patient, 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 for collection, the undersigned shall pay actual attorneys fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

I agree to pay the hospital in accordance with its regular rates and terms.

TERMS: Net 30 days from the date of invoice unless otherwise indicated on a promissory note. Should collection become necessary, the responsible party agrees to pay any additional collection fees, and all legal fees of collection without suit, including attorney fees, court costs and filing fees.

8. **Assignment of Insurance Benefits**: I authorize direct payment to the Hospital of any insurance benefit. I understand that I am responsible for any charges not paid by my insurer and I agree to pay any unpaid balances on my account no more than 90 days after the date of service.

9. **Disclosure of Ownership:** The physician who refers you to our Hospital may have a financial interest in this hospital. You are free to choose another hospital in which to receive services.

10. **Medicare Certification, Authorization to Release Information, and Payment Request:**

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

11. **HIPAA Privacy Notice:** I acknowledge that I have received the Facility's HIPAA PRIVACY notice and have had the opportunity to review its content._____ (Please initial)

12. **Patient Bill of Rights:** I acknowledge that I have received the Patient Bill of Rights._____ (Please initial)

Patient Signature:_____ Date: _____

Origination Date 9/25/2010