CONDITIONS OF ADMISSION

Patient's Name:_____

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I consent to the procedures that may be performed during this hospitalization or while I am an outpatient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, telehealth services, anesthesia, or hospital services provided to me under the general and special instructions of my physician or surgeon. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this hospital.

NURSING CARE

This hospital provides only general nursing care and care ordered by the physician(s). If I want a private duty nurse, I agree to make such arrangements. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

All physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist and others, are not employees, representatives or agents of the hospital. They have been granted the privilege of using the hospital for the care and treatment of their patients, but they are not employees, representatives or agents of the hospital. They are independent practitioners.

Patient initials:_____

I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

STUDENTS & VOLUNTEERS

I understand and consent to residents, interns, medical, and podiatry students, post-graduate fellows, and other medical trainees to observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of various medical education programs. In addition, students of ancillary healthcare professions (e.g., nursing, x-ray, and rehabilitation therapy) may observe, examine, treat and participate in my care under the supervision of a licensed ancillary healthcare professional.

I understand and consent to the use of volunteers for a variety of non-medical duties related to my visit at Valley Presbyterian Hospital.

MATERNITY PATIENTS

If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Admission apply to the infant(s).

PERSONAL BELONGINGS

As a patient, I am encouraged to leave personal items at home. The hospital maintains a fireproof safe for the safekeeping of money and valuables. The hospital is not liable for the loss or damage to any personal belongings or assistive devices that are not placed in the safe, including but not limited to: money, jewelry, documents, eyeglasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices, or other articles. Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500) unless I receive a written receipt for a greater amount from the hospital.

CONSENT TO PHOTOGRAPHY / VIDEOTAPING

I consent to the taking of photographs, videotapes, digital or other images of my medical or surgical condition or treatment, and the use of the images, for purposes of my identification, diagnosis or treatment or for the hospital's operations, including peer review and education or training programs conducted by the hospital.

ADVANCE DIRECTIVE

Do you have an Advance Directive _____YES _____NO or Patient is a Minor_____

If yes, name of person/agent designated in the Advance Directive _____ , _____

Please print (Last name) (First name)

Phone number of Designated Agent/Person ( ) _____-_____

Is there a copy of the Advance Directive in the chart _____YES _____NO

If No, name of person providing a copy for the chart _____ , _____

(Last name) (First name)

Phone number of person providing a copy of the Advance Directive ( ) _____- _____

Advance Directive brochure provided to patient _____YES _____NO

Patient would like to speak to Social Services regarding formulating an Advance Directive

_____YES _____NO

FINANCIAL AGREEMENT

I agree to promptly pay all hospital bills in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. I understand that I may review the hospital's charge description master before (or after) I receive services from the hospital. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. If my insurance or health benefit plan sends any payments directly to me, I agree to arrange for the immediate delivery of the payments to hospital, and will endorse or caused to be endorsed by my representative any checks and/or other documents necessary for the hospital. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

Patient initials:_____

ASSIGNMENT OF ALL RIGHTS AND BENEFITS

I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for the care I have been or will be provided in the future, as well as the right to sue to collect such payment. This

assignment shall also include the right to obtain copies of any plan documents or other information pursuant to which my insurance of health benefit plan is governed, the right to seek statutory or contractual penalties, fees and interest against any administrator or fiduciary of the plan; the right to seek appropriate equitable relief in connection with the provision of Services to me; and the right to sue any fiduciary or administrator for the plan for breach of fiduciary duty. I agree that the insurer or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment.

Patient initials:_____

I also hereby designate the hospital as my duly authorized representative to act on my behalf in connection with all matters arising from or relating to efforts to seek the insurance and health plan benefits payable for my care. I grant this hospital absolute power and authority to do anything that I would have been entitled to do in any legal, private, public, administrative, formal or informal process or forum. The hospital shall act as my authorized representative in any internal or external appeal, review, or grievance process; in connection with any request for verification of coverage or request for authorization of Services; in connection with any pre-service and post-service claim or appeal; and, if necessary, in litigation. I agree to cooperate with, and take all steps reasonably requested by this hospital to perfect, confirm, or validate its status as my authorized representative.

My initials below indicate that I have received the following documents:

___ Patient Rights and Responsibilities ___ Notice of Privacy Practices ___ Health Information Exchange Overview

___ Your Right to Make Decisions About Medical Treatment ___ A Patient's Guide to Blood Transfusion

___ Patient Financial Responsibility ___ Want to Quit Smoking

This hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the financial office. All physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if the hospital or the physicians providing services to me contract with my health plan.

I certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Date: _____ Time:_____ AM / PM

Signature:_____
Patient or Legal Representative

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

Print name: _____
(legal representative)

Signature:_____
(witness)

Print name: _____
(witness)

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Contracts provisions above.

Date: _____ Time:_____ AM / PM

Signature:_____
(Financially responsible party)

Print name: _____
(Financially responsible party)

Address: _____

Phone number:_____

Signature:_____
(witness)

Print name: _____
(witness)

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.