CONDITIONS OF ADMISSION

Patient's Name:_____

1. **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.
2. **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.
3. **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. 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. INITIALS
4. **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 also understand and consent to the use of volunteers for a variety of non-medical duties related to my visit at Valley Presbyterian Hospital. INITIALS
5. **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).
6. **DISCHARGE AGREEMENT:** If my treating physician orders my discharge, then I agree to vacate my room by the discharge time. If I hold the room past the discharge time, I will pay all charges I incur, including the room and bed charge for that day. INITIALS
7. **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. INITIALS

8. **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.

9. **ADVANCE DIRECTIVE:**

Is patient a minor?	☐ YES	☐ NO
Do you have an Advance Directive? If yes, name of designated person/agent?	☐ YES	☐ NO
Name: _____ Phone: _____		
Is there a copy of the Advance Directive in the chart?	☐ YES	☐ NO
If no, name, and phone number of person providing a copy for the chart?		
Name: _____ Phone: _____		
Advance Directive brochure provided to patient.	☐ YES	☐ NO
Would you like to speak with Social Services regarding formulating an Advance Directive?	☐ YES	☐ NO

10. **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, 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. I authorize the hospital, or a collection agency or other entity contracting with the hospital, to obtain credit reports about me from national credit bureaus in connection with payment of my account. INITIALS

11. **LIABILITY FOR NON-COVERED SERVICES:** If I receive services that are not covered by an Insurance Source, then I agree to pay all charges for those services to the extent permitted by law. I understand that I may receive separate bills for facility services and for professional services. INITIALS

12. **CREDIT BALANCES:** If there is a credit balance on my account (meaning that the amount paid is more than what is owed), I authorize Hospital to apply the credit balance to all other open or unpaid services on my accounts (or my guarantor's accounts) with Hospital, staring with the oldest outstanding account, including any accounts that have been assigned to bad debt (collections) as permitted by law. INITIALS

13. **MEDI-CAL PATIENTS WITH A SHARE OF COST (SOC):** This is to inform you of your Share of Cost amount as indicated on your Medi-Cal Eligibility verification. The Share of Cost is the Medi-Cal recipient's responsibility and must be paid at the time services are rendered. If you cannot pay your Share of Cost amount today, you can "obligate yourself" to pay at a later date upon receiving your statement by initialing here. INITIALS

14. **MEDI-CAL PATIENTS WITH PRESUMPTIVE OR LIMITED MEDI-CAL ELIGIBILITY STATUS:** This is to inform you of a potential liability due to your Presumptive or Limited Medi-Cal Eligibility status. Your benefit may or may not cover all or part of the services rendered to you. In addition, any non-covered services will be your responsibility, if you and your physician agree that the service and/or supply is necessary. INITIALS

15. **ASSIGNMENT OF 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 this hospitalization or for these outpatient services. 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. INITIALS

16. **LIST OF HEALTHPLAN CONTRACTS:** Please be advised that 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.

17. **FACILITY DIRECTORY:** I agree that Hospital staff may disclose my room location/phone number to visitors who ask for me by name. In addition, the Hospital may provide my religious affiliation, if any to clergy. Alternatively, I request that the Hospital withhold the following information from all visitors, including family members, inquiring about me: ☐ Name ☐ Phone Number ☐ Room ☐ Location

18. **ADMISSION/REGISTRATION INFORMATIONAL MATERIAL:**

My initials indicate that I have received the following documents. INITIALS

- 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
- TCPA OPT IN/OUT Form

19. CERTIFICATION:

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

Date: _____ Time:_____ AM / PM

_____

Signature of Financially Responsible Party:

_____

Printed Name of Financially Responsible Party

_____

Relationship to Patient (if Patient State "Self")

_____

Signature of Witness

_____

Printed Name of Witness

20. 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 of Financially Responsible Party:

_____

Printed Name of Financially Responsible Party

_____

Relationship to Patient Financially Responsible Party

_____

Phone Number of Financially Responsible Party

_____

Address of Financially Responsible Party

_____

Signature of Witness

_____

Printed Name of Witness

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