CONDITIONS OF ADMISSION

The undersigned patient is admitted to Hoag Memorial Hospital Presbyterian ("Hospital") for inpatient, outpatient and / or emergency treatment subject to the following terms and conditions:

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURE
   The undersigned consents to the procedures that 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, telehealth services, anesthesia, or hospital services rendered the patient under the general and special instructions of the patient's physician or surgeon. In order to meet the requirements of California law, assessments and tests may be performed or treatment rendered during the Hospital stay (such as PKU testing) for the welfare of the patient. The undersigned consents to such testing or treatment done pursuant to state law.

2. NURSING CARE
   This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged 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 the patient is not provided with such additional care.

3. PHYSICIANS ARE INDEPENDENT MEDICAL PRACTITIONERS
   All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, emergency department physician, anesthesiologist, hospitalist, and the like, are independent medical practitioners and are <u>not</u> employees or agents of the hospital. They have merely been granted the privilege of using the Hospital for the care and treatment of their patients. Physician fees are billed separately from Hospital charges, and, therefore, patients may receive multiple bills.

   Initial Here: _____

   The patient is under the care and supervision of his/her attending physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to 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. PERSONAL BELONGINGS
   The patient is 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 money, jewelry, documents, or other personal property items brought onto hospital property. The Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500) unless a written receipt for a greater amount has been obtained from the Hospital.

   Initial Here: _____

5. MATERNITY PATIENTS
If the patient delivers an infant(s) while a patient of this Hospital, the undersigned agrees that these same Conditions of Admission apply to the infant(s). Initial Here: _____

6. PARTICIPATION IN MEDICAL EDUCATION / TEACHING PROGRAMS
The undersigned acknowledges and understands that the Hospital participates in teaching programs and as such the training of physician fellows through a Medical Education Program, nurses and other health care personnel takes place at the Hospital and these individuals may participate in the operation, special diagnostic or therapeutic procedures, or treatment specified above under appropriate supervision and the undersigned hereby consents.

7. CONSENT TO PHOTOGRAPH
The undersigned consents to be photographed (includes video or still photography, in digital or any other format, and any other means of recording or reproducing images) while receiving treatment at the Hospital, with the understanding that the images from such photography may be used for the patient's treatment or for Hospital health operations such as peer review or medical education, as the Hospital or the patient's treating physician(s) deem appropriate.

8. 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 promptly pay the account of the Hospital in accordance with the regular rates and terms of the Hospital, including its charity care and discount payment policies, if applicable. The undersigned understands that all physicians and surgeons, including the radiologist, pathologist, emergency department physician, anesthesiologist, hospitalist, and others, will bill separately for their services. Should any 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.
Initial Here: _____

9. ASSIGNMENT OF INSURANCE BENEFITS
The undersigned assigns and authorizes, whether he / she signs as agent or as patient, direct payment to the Hospital of any insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services. It is agreed that payment to the Hospital, pursuant to this authorization, by an insurance company shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he / she is financially responsible for charges not paid according to this assignment.

10. HEALTH PLAN (INSURANCE) OBLIGATION
This Hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the Admitting and Registration Office. The Hospital has no contract, express or implied, with any plan that does not appear on the list. It is the patient's obligation to assure that the patient's health plan has authorized the services to be provided by the Hospital. The undersigned agrees that he / she is individually obligated to pay the account of the Hospital in accordance with the regular rate and terms of the Hospital, including its financial assistance policies, if he / she belongs to a plan which does not appear on the above-mentioned list or if the patient fails to obtain the health plan's authorization.

All physicians and surgeons, including the radiologist, pathologist, emergency department physician, anesthesiologist, hospitalist, and others, will bill separately for their services. It is the responsibility of the undersigned to determine if physicians providing services to the patient contract with the patient's health plan, if any. Initial Here: _____

11. ACKNOWLEDGEMENTS

a. This is to acknowledge that the undersigned has received the *Patient Information* brochure which addresses *Patient Rights* and how to file a grievance, *Patient Responsibilities,* and *Your Right to Make Decisions about Medical Treatment* (Advance Health Care Directive information) among other information.

b. The undersigned acknowledges and understands that from time to time, the Hospital may provide services to its hospital patients through the use of outside resources or under arrangements with third parties, including, for example, services provided to Hospital patients by specialty reference laboratories or Hoag Orthopedic Institute. In these circumstances, the Hospital retains professional and administrative responsibility for all services provided to its Hospital patients by these outside resources.

Initial Here: _____

12. LAB TEST RESULT ACKNOWLEDGEMENT

I hereby request and agree that my laboratory test results may be provided to the Patient Portal, so that I may access them electronically as part of my clinical health record. I understand that the laboratory test results made available through the Patient Portal will not include test results for HIV, hepatitis, drug abuse, or a malignancy. ☐ Yes ☐ No Initial Here: _____

13. CALIFORNIA IMMUNIZATION REGISTRY

Hoag may share your immunization or tuberculosis (TB) screening test records with the California Immunization Registry (CAIR), a statewide, secure and confidential database of patient immunization information. The CAIR is used by health care professionals, agencies, and schools to keep track of all shots and TB tests you take, and can provide proof about immunization needed to start child care, school, or a new job. If you do not want your immunization or TB records to be shared with other registry users, please fax or email the "Decline or Start Sharing/Immunization Information Request Form," available on the CAIR website at http://cairweb.org/cair-forms/, to the CAIR Help Desk at 1-888-436-8320 or CAIRHelpDesk@cdph.ca.gov. Initial Here: _____

14. TELEPHONE CONSUMER PROTECTION AND CAN-SPAM ACTS

By providing us with a telephone number for a cellular or other wireless device, you agree that, in order for us or our service providers to service your account(s) (including contacting you about obtaining potential financial assistance for your account(s)), or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you which could result in charges to you. You expressly consent that methods of contact may include using pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with your account number(s) and is not a condition of purchasing property, goods, or services. You are not required to initial this section as a condition of admission.

If Opting Out please check: ☐ Initial Here: _____

Patient Identification

The undersigned certifies that he / she has read the Conditions of Admission, received a copy, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____ _____ _____ A.M./P.M.
[Signature of Patient/Legal Representative] [Date] [Time]

_____ _____
[If signed by other than patient, indicate relationship] [Hospital Representative]

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 Obligation provisions above.

_____ _____ _____ A.M./P.M. _____
[Signature of Financially Responsible Party] [Date] [Time] [Hospital Representative]

Interpreter's Statement:
The foregoing document was translated by the interpreter (listed below) to the patient or legal representative in the patient's or legal representative's primary language (indicate language): _____. He/she understood all of the terms and conditions and acknowledged his/her agreement with the above document.

_____ ☐ Interpreter Service
[Interpreter Name and Identification Code – Print]

_____ _____ _____ A.M./P.M.
[Witness] [Date] [Time]

Patient Identification