

CONDITIONS OF ADMISSION - OUTPATIENT

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, TERM/DURATION OF CONSENT

The undersigned consents to the procedures that may be performed during this outpatient service treatment or services, or any other services, whether inpatient, outpatient, or emergency, performed at any Hospital facility while this consent remains in effect, which may include, but are not limited to, laboratory procedures, x-ray examinations, MRI, ultra sound or other out patient services. This consent will remain in full force and effect and be valid for the period of one year from date of the signing by the patient at Section 11 below, or until consent has been revoked in writing.

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 **not** 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 to these same Conditions of Admission on behalf of the infant(s). **Initial Here:** _____

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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 to such participation.

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 only 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, but for no other purposes.

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 which includes, Steps to Improve the Safety of Your health Care, *Rights and Responsibilities as a Patient*, and *Your Right to Make Decisions About Medical Treatment* (Advance Healthcare Directive 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. 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: _____

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/Parent/Conservator/Guardian] [Date] [Time]

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

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]

CONDITIONS OF ADMISSION - OUTPATIENT

Patient Identification

HOAG

MEMORIAL

HOSPITAL

PRESBYTERIAN

Irvine • Newport Beach

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Hoag Memorial Hospital Presbyterian ("Hoag") including Hoag entities, may share my health information for treatment, billing and healthcare operations. I have been provided a copy of Hoag's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Hoag has the right to change this notice at any time. I may obtain an additional copy by contacting the hospital registration office or by visiting the website at www.hoag.org.

I acknowledge receipt of the Notice of Privacy Practices of Hoag Memorial Hospital Presbyterian.

Patient's Name: _____

Signature: _____ Date: _____

[Patient/Parent/Conservator/Guardian]

If signed by other than patient, indicate relationship: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

- Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgement of Receipt.
- Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices.
- Other: _____

Patient's Name: _____

Hoag Staff Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

JIT 3990

Rev 08/23/10



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