

Patient Name	
Medical Rec. #	LABEL
Physician	

## Hospital Conditions of Admission

- 1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES:** 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 not be limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, telehealth services or hospital services rendered to the patient under general and special instructions of the patient’s physician or surgeon. The undersigned agrees to photographic documentation, production of recordings, films, or other images to assist in their treatment.
- 2. NURSING CARE:** This hospital provides only general duty nursing care unless, upon an order of the patient’s physician, the patient is provided more intensive care. If the patient’s condition is such as to need the service of a special duty nurse, it is agreed that such service must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the service and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.
- 3. PHYSICIANS ARE INDEPENDENT CONTRACTORS:** All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors and are not employees or agents of the hospital. Some of these physicians will bill separately for their services. Patient initials:\_\_\_\_\_.
- 4. RELEASE OF INFORMATION FOR TREATMENT:** Upon inquiry, the hospital may make available to the public upon request only by patient name limited information about the patient, including location in the hospital and general condition. If the patient or the patient’s legal representative does not want such information to be released, he/she must make a written request for such information to be withheld. The patient or the patient’s legal representative may obtain a separate form for this purpose upon request. The undersigned agrees that all or part of the patient’s record may be forwarded to a physician, another hospital, a nursing home, other treatment facility, home health agency or other provider of health care in the event of the patient’s transfer or discharge.
- 5. REPORTING OF COMMUNICABLE DISEASES:** This hospital is required by law to disclose or report to organizations such as public health departments and/or Centers for Disease Control and Prevention (CDC) communicable diseases, including but not limited to, cases of HIV, tuberculosis, viral meningitis, and other diseases.
- 6. PERSONAL VALUABLES:** It is understood and agreed that the hospital maintains a fireproof safe for the safekeeping of money and valuables, and 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, unless placed therein, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited by statute to five hundred dollars (\$500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient

*A copy of this document should be given to the patient and any other person who signs this document.*

**WHITE** - Medical Records      **CANARY** - Patient



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**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.

**8. ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned 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 of this hospitalization or for those outpatient services, including emergency services if rendered. It is agreed that payment to be the hospital, pursuant to this authorization, by an insurance company shall discharge said 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 pursuant to this agreement.

**9. HEALTH PLAN OBLIGATION:** 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. The hospital has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by the hospital if he/she belongs to a plan that does not appear on the above-mentioned list.

**10. ADVANCE DIRECTIVES:**

I have an Advance Healthcare Directive - Received by: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Registrar Initials)*  
\_\_\_\_\_ *(name)* is named as my surrogate decision maker and is responsible for providing a copy of my Advance Directive to the hospital.

I do not have an Advance Healthcare Directive. The Advance Directive information pamphlet, Your Right to Make Decisions About Medical Treatment has been provided to me.

Received by: \_\_\_\_\_ Date: \_\_\_\_\_  
*(Patient's Initials)*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM  
*(patient / parent / conservator / guardian)*

If signed by other than patient, indicate relationship: \_\_\_\_\_

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 Obligation provisions above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM / PM  
*(financially responsible party)*

Witness: \_\_\_\_\_

***A copy of this document should be given to the patient and any other person who signs this document.***

