CONDITIONS OF ADMISSION
(For Use for Inpatients, Outpatients and Emergency Department Patients)

Terms Used in this Form

"Hospital" means: St. Joseph's Hospital and Medical Center.
"Patient" means the person identified in the registration block.
"Patient's legal representative" can be the Patient's parent, guardian, conservator, or any other person authorized to sign this document on the Patient's behalf, such as an agent under an advanced directive.
"You" or **"Your"** refers to the person signing this document and can be the Patient or the Patient's legal representative.
"We" or **"us"** or **"our"** refers to the Hospital.
"Insurance company" means a HMO, health plan, indemnity plan, government plan or insurance company.
"Full charges" means the Hospital's published rates (called the chargemaster), prior to any discounts or reductions.

By signing this form, You agree to all of the following provisions:

1. Consent to Medical and Surgical Procedures
You consent to the procedures that may be performed during this Hospital stay or provided as an outpatient. These may include emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, anesthesia, or other hospital services provided to the Patient under the general and special instructions of the doctor. Some treatment or services may be provided through telemedicine. You agree that the Hospital and doctors may access and use your non-hospital pharmacy records in connection with this Hospital stay or visit. You understand that the practice of medicine and surgery is not an exact science. You understand that diagnosis and treatment may involve risks of injury or even death. You acknowledge that We make no guarantees to You about the result of examination or treatment in this Hospital. If the Patient delivers an infant(s) at this Hospital, You agree that these same Conditions of Admission apply to the infant(s).

2. Consent to Electronic Recording
You consent to our use of photography, audio or video recording or other electronic imaging as required for diagnosis or treatment of the Patient and for other internal Hospital purposes. We will not use the Patient's image for marketing or fundraising unless we get Your separate authorization in writing. We may take the Patient's picture to confirm and protect his/her identity.

3. General Duty Nursing Care
The Hospital provides only general nursing care and services ordered by the doctor(s). If You want a private duty nurse and the doctor agrees, You agree to make the arrangements at the Patient's expense. The Hospital is not responsible for not providing a private duty nurse. You release the Hospital from any and all liability from the use of a private duty nurse or the fact that the Hospital does not provide this additional care.

4. Participation of Residents and Health Care Students
We may participate in programs to teach resident doctors, medical students, student nurses, and/or other health care students. These persons may observe or participate in the Patient's care under the supervision of doctors, nurses and other professionals on the Hospital's staff.

5. Doctors are Independent Medical Care Providers

Doctors caring for patients in the Hospital may be employees of the hospital or independent providers of medical ca Independent providers are members of the hospital medical staff but are not employees or agents of the hospital. These doctors are also responsible for giving you information about the risks, benefits, and alternative kinds of treatment so that you can make an informed decision about the Patient's care. The Hospital's nurses and staff are responsible for carrying out the instructions of the doctor(s). You will receive a separate bill from the doctors for their services.

Patient/Legal Representative Initials: _____

You understand that the Patient is under the care and supervision of the attending doctor. The Hospital and its staff are responsible for carrying out the doctor's instructions. Your doctor or surgeon is responsible for obtaining Your informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or Hospital services provided to You under your doctor's general and special instructions.

6. Release of Information

You will be given a Notice of Privacy Practices that explains how the hospital may use information about the Patient. The Notice of Privacy Practices is available on the Hospital's website under *Patient Privacy Notice*. The Notice of Privacy Practices explains that we will obtain Your written authorization to release information about the Patient, unless We are allowed or required by law to disclose the information without authorization.

7. Personal Belongings

You should 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 articles not placed in the safe. Hospital liability for loss of any personal property given to the Hospital for safekeeping is limited by law to five hundred dollars ($500) unless You receive a written receipt for a greater amount.

8. Financial Agreement; Assignment of Benefits/Appeal Rights

a. Insured Patients. We will bill the patient's insurance company for all the services provided during this stay. Co-payments, co-insurance and deductibles required by the insurance company must be paid by the Patient. Payment may be requested before or at the time of service. If the insurance company or benefit plan denies all or part of the payment, the Patient agrees to be responsible to pay any amounts due to the Hospital under the law. The Patient also assigns all the Patient's rights under the Employee Retirement Income Security Act ("ERISA") or any other applicable state or federal law to Hospital to appeal the denial or underpayment and to seek all legal remedies on behalf of the Patient in any forum against any entity. Some common reasons an insurance company may deny payment are:

· The service is not covered
· The hospital is not in the insurance company's network
· Advance authorization from the insurance company was required and not obtained
· The insurance company determines the service is not medically necessary

By signing this form, You authorize us to submit a claim for payment to the Patient's insurance company or benefit plan for the services provided to the Patient. You authorize us to dispute any denials or underpayments to, or legally pursue legal remedies against, the Patient's insurance company or benefit plan. You authorize and direct the insurance

company or benefit plan to make direct payments to us for such services, and to accept and adjudicate appeals from the Hospital on your behalf. You appoint Hospital as the Patient's personal representative to pursue all benefit rights. You also agree the Patient is financially responsible as allowed by law for any charges not paid by the insurer or benefit plan.

b. Uninsured Patients. Patients without insurance must pay for services at full charges, unless other discounts apply. Uninsured patients may qualify for government programs or financial assistance. Financial assistance may include a discount from the Hospital's full charges, free care, interest free payment plans or other assistance. Patients asking for government or financial assistance must complete an application (see Paragraph 9 below).

c. Additional Terms. (i) **We may disclose your information to other agencies or firms as needed, for the sole purpose of getting a standard credit report on the undersigned. That credit report may include investigations of personal credit history, employment and other financial situations.** (ii) All past due accounts will be charged interest at the legal rate. If we send the Patient's account to a collection agency or an attorney, the Patient agrees to pay the Hospital's reasonable attorneys' fees, costs and collection expenses. (iii) If a person other than You (or the Patient's estate) agrees to pay for the services provided to the Patient during this stay, that person must sign the Financial Responsibility Agreement below.

9. Financial Assistance

We can help uninsured patients enroll in government health care programs, such as Medicaid. If the Patient is uninsured and does not qualify for government programs, financial assistance may be available under Dignity Health's Patient Financial Assistance Policy. To get assistance under this policy, You must complete an application and give certain financial information. You will be given a brochure that explains our billing process and our financial assistance programs. You may ask to talk to financial counseling staff at any time.

10. Third Party Liability

If We are treating the Patient for injuries caused by the actions of others, We may have the right to additional payments if the Patient recovers money from the person or entity that caused the injury. If allowed by law, We may make a claim against any award of money to the Patient. We may recover an amount equal to the difference between full charges and the amount the Patient or the Patient's insurance company paid for the Hospital services. You agree to provide us with the name of any person that may have caused the Patient's injuries, the name of the person's insurance company, the name of the Patient's lawyer and any other information that may help us exercise our rights.

11. Patient Certification: *By signing this form, You certify that:*

- *You have read this form*
- *You have received a copy of the form*
- *You were given the opportunity to ask questions*
- *You understand what it means*
- *You are the Patient or the Patient's Legal Representative*
- *You have received the Hospital Billing Process brochure.*
- *You have received information informing You of your Patient Rights and Responsibilities.*
- *You have received information advising You of the Hospital's policy for implementation of defined Advance Directives.*

Signature: _____ Date: _____ Time: _____A.M./P.M.
[Patient or Patient's Legal Representative]

Name:_____ Relationship to the Patient: _____
[Print Name]

Witness Signature: _____

Financial Responsibility Agreement by Person Other than the Patient or Patient's Legal Representative:
I agree to accept financial responsibility for services rendered to the Patient. In particular, I accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Third Party Liability provisions as stated above.

Signature: _____ Date: _____ Time: _____A.M./P.M.
[Financially Responsible Party]

Name:_____ Relationship to the Patient: _____
[Print Name]

Witness Signature: _____

For Hospital Use Only: Compliance with Advanced Directives Policies
Hospital representative must check one and sign:

❑ The Patient is incapacitated or otherwise unable to communicate, the advance directive information has been provided to the patient's family or surrogate in accordance with Federal and State law.

❑ The Patient is unable to receive information regarding advance directives at this time and is not accompanied by a legal representative. A referral will be made to the Hospital Department responsible for follow-up.

❑ The Patient has been given written information about his/her right under state laws to make advance directives and written Hospital policies regarding the Hospital's implementation of such right.

❑ The Patient has a written advance directive about health care decisions and:
- ❑ A copy has been provided to the Hospital.
- ❑ A copy has not been given to the Hospital, but the Patient has been informed of Patient's responsibility to give a copy to the Hospital.

❑ The Patient does not have a written advance directive about health care decisions and:
- ❑ Wants information; a follow-up referral will be made.
- ❑ Does not wish further information now.

Completed by: _____ Date: _____ Time: _____