HARRISON COUNTY HOSPITAL

Patient Label

**CONDITIONS OF ADMISSION AND AUTHORIZATION FOR TREATMENT**

□ Harrison County Hospital □ Harrison County Hospital Physician Group

□ After Hours Care

## I. CONSENT TO DIAGNOSTIC TESTS, PROCEDURES AND MEDICAL TREATMENT:

I voluntarily consent to care that involves routine diagnostic test, procedures, and medical treatment as prescribed by my physician and performed by the facility. No guarantee has been given by anyone as to the results that may be obtained. This consent includes testing for Hepatitis, Human Immunodeficiency Virus (HIV) or any other blood-borne infectious diseases, if ordered for diagnostic purposes or due to an occupational exposure. If I am consenting to routine diagnostic tests, procedures or medical treatment on behalf of an individual other than myself, I certify that I am authorized to consent to such services on the individual's behalf as either parent, guardian, or qualified patient advocate. Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information. I acknowledge and consent to care provided to me via telehealth/telemedicine.

## II. RELEASE OF INFORMATION:

I authorize the facility to notify my referring and treating physician(s) of my admission, transfer and discharge and to release any information about me as requested by such physician(s). I authorize the facility and any other holder of medical or other information about me, including medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood-borne infectious diseases, to the Social Security Administration, its intermediaries and carriers, State agencies, the review organization employed by my employer, or the employer of the insured member of my family, or any private third-party payor, as appropriate, any information required for the completion of any claim for benefits arising out of services rendered to me either on an inpatient or outpatient basis. I further authorize the release of my social security number to the manufacturer of any implanted medical device in accordance with the Medical Device Tracking Act of the Food and Drug Administration (FDA). I authorize the release of my HIV test results to health care personnel in the event of an occupational exposure. If my injury is work-related, I authorize the facility and any other holder of medical or other information about me to release from my medical record any information as requested by the company/employer and/or its worker's compensation administrator.

## III. THE FACILITY IS NOT RESPONSIBLE FOR LOSS OF PERSONAL ARTICLES:

I accept full responsibility for items of personal property kept in my possession. I understand that the facility maintains a safe for safekeeping of money and valuables and the facility shall not be liable for the loss of or damage of any money, jewelry, documents or any other items of personal property, unless deposited in the facility safe for safekeeping.

## IV. ASSIGNMENT OF BENEFITS:

I agree to the assignment of all third-party benefits to the facility and agree to pay the facility for all charges not covered by the third-party payors. In the case of outpatient services, I agree that this document shall remain in full force until specifically revoked by me in writing. Any sums not paid by a third-party payor are my obligation.

## V. PAYMENT OF FACILITY BILLS WHEN DUE:

I am liable for the payment of the account of the facility, I am obligated to pay the account of the facility, in accordance with the regular rates, and terms of the facility, even if the services rendered are eligible for payment by my health insurance. I agree to pay applicable co-payments, deductibles, and similar amounts, which may be collected at the time services, are rendered. If my injury is work-related, I am further obligated to pay the account of the facility in the event my employer or its third-party administrator denies payment for worker's compensation. I understand that after reasonable notice, delinquent accounts may be referred to a collection agency and/or an attorney for collection. Should it be necessary to place this account in the hands of a collection agency and/or attorney for collection, I agree to pay the costs of collection, including any court costs, interests, and a reasonable fee to the attorney employed by the facility to collect the amounts owed on the account. I give Hospital permission to obtain a copy of my credit report, if needed, to be used in determining eligibility for Hospital

financial assistance. Depending on my insurance, I acknowledge that the hospital and the treating employed physician may each generate their own charges and separately bill my insurance company.

## VI. PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO ARE INDEPENDENT PRACTITIONERS AND SUPPLIERS OF SERVICES AND OUT OF NETWORK NOTICE:

I understand and acknowledge that I may require the services of physicians, groups of physicians, or other practitioners (such as nurses and physician assistants) to render health care items or services WHO ARE NOT EMPLOYEES OF THE HOSPITAL including, but not limited to, anesthesiologists, radiologists, emergency department physicians, certified registered nurses, anesthetists, and other practitioners. I also understand that residents, fellows, medical students and students of various health care fields may be involved in my care and that they are not employees of the hospital. I agree that the signing of this document does not in any way imply that Harrison County Hospital is responsible for or assumes any liability for the activities of any of such physicians or practitioners who are not its employees. When a physician, other practitioner or supplier of services bills me directly, I agree to pay the bill and acknowledge that the provider or supplier may be out of network with respect to my insurance plan. Payment provisions of my health plan do not bind the out of network provider and that I may contact my health plan for assistance. I agree that the provisions regarding the release of information and assignment of benefits set out in paragraphs III and IV below shall apply not only to the hospital but also to such physicians, practitioners and suppliers of services and their claims for payment.

I acknowledge the above statement: _____ (Initial)

Patient Label

**A Copy of the following Notices and/or Policies has been made available to me:** *(Initial Each Appropriate Line)*

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| **Patient Bill of Rights** | Accepted: _____ | Not Accepted: _____ | Received on Prior Visit: _____ |
| **Privacy Notice** | Accepted: _____ | Not Accepted: _____ | Received on Prior Visit: _____ |
| **Visitor Policy** | Accepted: _____ | Not Accepted: _____ | Received on Prior Visit: _____ |
| **Protections Against Surprise Medical Bills** | Accepted: _____ | Not Accepted: _____ | Received on Prior Visit: _____ |

## X. OTHER:

If I have provided the facility with my cell phone number and/or email address, I agree that the facility, its agents, and contractors may contact me on that phone number, or by using an automated telephone dialing system, or prerecorded or artificial voice, or via text message or via email to collect any amounts I owe or to remind me of upcoming appointments.

I acknowledge that my medical and/or mammogram images will be archived at Harrison County Hospital for a period of at least 5 years. At the end of that 5-year period, I have 30 days to claim a CD copy of my images before they are purged from the image file system. I am also aware that I may obtain a CD copy of my medical and/or mammogram images at any time during that 5-year period and that this copy will be provided by the hospital at cost. Note: If no additional mammograms are performed, the initial mammogram will be archived for a period of not less than 10 years.

## XI. TOBACCO-FREE CAMPUS:

I understand that Harrison County Hospital is a tobacco-free campus and that the use of all tobacco products including cigarettes, smokeless tobacco and cigars are prohibited on all hospital and hospital-based properties.

The undersigned certifies that he/she has read or has had read to them, understands and agrees to this agreement and has received a copy. The undersigned certifies that the patient is unable to consent or is a minor and the undersigned hereby consents to the above as indicated below. The undersigned agrees that a copy of this release and assignment may be used in place of the original copy.

SIGNED:_____ RELATIONSHIP TO PATIENT:_____

WITNESS:_____ DATE:_____