RADIOLOGY STUDIES ARE INTERPRETED HERE AT THE HOSPITAL

1. 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 said patient is not provided with such additional care.

2. CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, newborn hearing screening program, medical or surgical treatment or procedures, anesthesia, or hospital services rendered the patient under the general and special instructions of the patient's physician or surgeon.

   As per the state of California's Safe Drinking Water and Toxic Enforcement Act, commonly known as "Proposition 65", you are entitled to information regarding products used that may contain chemicals known to cause cancer or reproductive toxicity. A list is available upon request from your physician, the nursing supervisor or the safety office.

3. RELEASE OF INFORMATION: Upon inquiry, the hospital may make available to the public certain basic information about the patient, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning, or other condition), general nature of the injury, burn, poisoning or other condition 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 hospital will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the hospital is permitted or required by law to release information.

   The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the hospital may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the hospital's charges, including but not limited to insurance companies, health care service plans, or workers' compensation carriers. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.

4. PERSONAL VALUABLES: It is understood and agreed that the hospital maintains a safe for the safekeeping 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 property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited to statute to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

5. 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 attorney's fees and collection expenses.

6. MEDICARE ASSIGNMENT/ RECEIPT OF IMPORTANT MESSAGE FROM MEDICARE: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf. I have received the important Message from Medicare if applicable to this admission.

7. PRIVATE ROOM AGREEMENT: The undersigned agrees to pay private room daily rate for each day a private room is provided pursuant to physician's order or patient's request.

8. The undersigned consents to the filming or recording of any medical, surgical condition or treatment and it's use for diagnostic, treatment, educational or training purposes. Consent is also given for photographing my newborn (s) for possible purchase of picture and security.

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CONDITIONS OF ADMISSION AND TREATMENT

9. 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 undersigned for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's regular charges. It is agreed that payment to 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 covered by this agreement.

10. HEALTH CARE SERVICE PLAN OBLIGATION: This hospital maintains a list of the health care service plans with which it has contracted. 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 cost mentioned list.

11. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN: All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist/ anesthetist and the like, are independent contractors with the patient and are not employees or agents of the hospital and may bill separately for their services. Patient Initials_____ . The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered under the general and special instructions of the physician.

12. TELEPHONE CONTACT: I authorize the hospital and all clinical providers who have provided care to me, along with any billing services, collection agencies, attorneys or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.

13. ASSIGNMENT OF INSURANCE BENEFITS TO PHYSICIAN: I hereby authorize payment directly to my physician for benefits otherwise payable to me for my hospitalization. I hereby agree that the doctor may receipt for any such payment and that its receipt shall be a conclusive acknowledgment by me that I have received benefits from the insurance company in the sum specified in such receipt, and agree that such payment shall discharge the insurance company of any and all obligations under the policy to the extent of such payment and for that purpose I expressly authorize the said hospital or the doctor in charge of my case to furnish the insurance company with whatever information it desires concerning said hospital care and medical or surgical treatment. I understand that I am financially responsible for the charges not covered by this agreement.

14. TEACHING PROGRAM: To the extent that the hospital conducts teaching programs to which the patient's condition or treatment is pertinent, students shall be permitted to participate in the care of the patient unless the hospital is notified to the contrary in writing.

15. SECURITY CAMERAS: This Hospital maintains security cameras located in different areas to provide a visual record of incidents pertaining to the safety and security of patients, visitors, staff and property.

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

_____ _____ _____

Date *Time* *Patient / Parent / Guardian / Conservator*

_____ *If other than patient, indicate relationship:* _____

Witness

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CONDITIONS OF ADMISSION AND TREATMENT

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 Care Service Plan Obligation Provisions above.

Date	*Time*	*Financially Responsible Party*

Witness

A COPY OF THIS DOCUMENT IS TO BE DELIVERED TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.

ORIGINAL - Medical Records COPY - Patient

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CONDITIONS OF ADMISSION AND TREATMENT