

CONDITIONS OF ADMISSION

1. **CONSENT TO HOSPITAL PROCEDURES:** The patient consents to the medical and surgical procedure, which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services. These may include but are not limited to laboratory tests, x-ray examinations, medical or surgical treatment or procedures, anesthesia, photographic/video records or hospital services rendered to the patient under the general and special instructions of the physician or surgeon. The attending physician must verbally inform the patient that telehealth may be used, and obtain verbal consent from the patient for this use. The verbal consent must be documented within the patient's medical record by the attending physician. The exception for this consent is for any patient that is under the jurisdiction of the Department of Corrections or any other correctional facility.

The patient consents to the taking of pictures of his/her medical or surgical condition or treatment, and the use of the pictures for purposes of diagnosis or treatment or for the hospital's operations, including peer review and education or training programs conducted by the hospital.

2. **CONSENT TO BLOOD TESTING:** In the event of an exposure of blood or body fluids to a health care worker, I acknowledge that the patient's blood will be tested for bloodborne viruses including Human Immunodeficiency Virus (HIV). The results of the test are necessary to determine whether the exposed health care worker needs immediate preventive treatment. The physician will inform the patient of the accidental exposure, test completion and results. _____ Initials
3. **NURSING CARE:** The patient understands that this hospital provides only general duty nursing unless, upon orders of the physician, the patient is provided more intensive nursing care. If the patient's condition requires a special duty nurse, the patient agrees that it must be arranged by the patient or their legal representative. The hospital will not be responsible for failure to provide the same and is released from any liability arising there from.
4. **TRAINING AND EDUCATION:** The hospital participates in the training of residents, medical students, students nurses and other healthcare personnel. I agree that they may participate in my care to the extent deemed appropriate by the Medical Staff or Hospital personnel, and I consent to the demonstration, observation and administration of treatment or procedures by such persons under the supervision of the members of the Medical Staff or Hospital personnel.
5. **MEDICATIONS:** The patient understands and agrees not to bring any medications (including non-prescription, prescription, and herbals) into the hospital. This applies to both inpatient and outpatient services. Patient agrees to provide hospital with a list of all medications (including non-prescription, prescription and herbals) that he/she is currently taking. _____ Initials
6. **PERSONAL VALUABLES:** The patient understands and agrees that the hospital maintains a safe for the safekeeping of money and other valuables, and that the hospital shall not be liable for the loss of such valuables unless they are deposited with the hospital for safekeeping. Liability of the hospital for loss or damage is limited by statute to five hundred dollars. The patient understand that he/she is responsible for personal effects, including personal grooming articles, jewelry, clothing, documents, medication, eye glasses, hearing aids, dentures and other prosthetic devices. _____ Initials
7. **NON-SMOKING HOSPITAL:** The patient understands that no smoking is permitted within the hospital except in designated places.
8. **PATIENT RIGHTS AND RESPONSIBILITIES:** The hospital retains a patient representative who the patient may contact regarding concerns about care and treatment. The patient/agent has received a copy of Patient Rights and Responsibilities. _____ Initials
9. **RELEASE OF INFORMATION:** To obtain payment for service, the patient/agent authorizes the hospital/provider to disclose to the patient's insurance carrier, health service plan, workers compensation carrier, or rendering physician any and all medical and basic information including name, location and general condition. If the patient doesn't want such information released, he/she may make a written request for such information to be withheld. A separate form is available for this purpose upon request. How Tri-City Medical Center may further use or disclose patient identifiable medical information about you, including disclosures for purposes of treatment, payment and health care operations is described in the Notice of Privacy Practice. The undersigned acknowledges having been offered a copy of the Notice and may request an additional copy at this time or access at www.tricitymed.org. _____ Initials
10. I authorize TRI-CITY MEDICAL CENTER, its service providers (including service providers contacting me about obtaining financial assistance for my account(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using pre-recorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.
11. **FINANCIAL AGREEMENT:** It is agreed, whether signed as agent or patient, that in consideration of the services to be rendered to the patient he/she individually obligates him/herself to pay the account of the hospital in accordance with regular rates and terms of the hospital including its financial assistance policies. Should the account be referred to an attorney or collection agency for collections, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
12. **ASSIGNMENT OF BENEFITS:** The patient or agent, hereby authorizes direct payment to the hospital/provider, any insurance benefits, including but not limited to third party liability payable to or on the patient's behalf for this hospitalization or for these services, including emergency services if rendered, at a rate not to exceed the hospital's billed charges. It is agreed that payment to the hospital by an insurance company shall discharge the insurance company of all obligations under a policy to the extent of such payment.

The patient understands that he/she is financially responsible for charges not covered by this assignment. This assignment is irrevocable.

13. PHYSICIANS ARE INDEPENDENT CONTRACTORS: All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, the emergency department physician 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 and may not have agreements with same insurance plans as the hospital. The undersigned acknowledges receipt of the Patient Notification Form and may request an additional copy at this time. _____ Initials

The patient is under the care of 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 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.

14. 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 Patient Financial Services. 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 covered services rendered to him/her by the hospital if he/she belongs to a plan, which does not appear on the above-mentioned list.

The undersigned certifies that he/she has read the foregoing, 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.

15. VISITORS: You have the right to visitors of your choice, including spouse, domestic partner (including same sex domestic partners), another family member or a friend.

Name: Patient/Legal Representative Signature: Patient/Legal Representative Date (m/d/y) ____/____/____ : ____ AM/PM

If signed by other than patient, indicate relationship:

Parent Spouse Partner Relative Conservator Tutor/Legal Guardian

If patient is unable to sign, state reason: _____

Interpretation provided: Language: _____

Telephonic VRI _____

Interpreter: Name or ID No. _____

Face-to-face interpreter Signature: _____

Witness/Representative of Tri-City Medical Center (print name) 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 and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits and Health Plan Obligation provisions above.

Signature: _____
(Financially responsible party) (print name)

Date/Time: _____

Witness: _____
(TCMC representative) (print name)

Date/Time: _____



4002 Vista Way • Oceanside • CA • 92056

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Affix Patient Label