PATIENT LABEL

CONDITIONS OF TREATMENT FOR HOSPITALS

INCLUDES PROVIDER-BASED LOCATIONS

Consent to Medical Care: I request and consent to the medical care and diagnostic treatment procedures as determined necessary by my physician(s) or his/her assistants. I acknowledge the care I receive while in this facility is under the direction of my physician(s).

Independent Medical and Allied Health Care Providers: I have been informed and understand: a) that physician(s) providing services to me in this facility, such as my personal physician(s), radiologists, pathologists (except for Illinois), anesthesiologists, emergency department physicians, consulting physicians, surgeons and other allied health care providers such as psychologists and nurse anesthetists, are independent contractors and are not employees or agents of this facility unless otherwise specifically identified, (b) that all these persons exercise their own independent professional judgment in my care and treatment, (c) this facility cannot and does not control the professional actions and judgment of such independent providers, and, (d) this facility is not responsible for the acts or omissions of these health care providers.

Teaching Programs: I understand this facility may, from time to time, enter into agreements with academic medical, nursing and allied health programs. Because of these agreements, residents, interns, medical students, nursing students and various allied health profession students, may participate in my care. I agree to participate in these programs, but have the right to limit my participation at any time.

Release of Information: I have received on this visit/admission or a previous one, the Notice of Privacy Practices that explains how the facility may use my information. I agree that this facility may use and release information about me as set forth in the Notice of Privacy Practices. The Notice of Privacy Practices is also available on the SSM Health website. As explained in the Notice of Privacy Practices, the facility will only obtain my written authorization to release information about me if use or release of my information without authorization is not permitted either by law or the Notice of Privacy Practices.

Medicare/Champus/Tricare Rights: If applicable, I acknowledge receipt of the Medicare/Champus/Tricare Letter explaining my rights as a patient of this facility. I understand this includes my right to request a review.

Patient Rights: I acknowledge receipt of the Patient Rights information explaining my rights as a patient in this facility.

Personal Property: I have been informed and understand this facility will not be liable for any loss of my personal property unless it is inventoried and placed in a secured area maintained by this facility.

Payment for Medical and Related Care: I agree to pay the facility's set and established charges incurred for the care I receive as ordered by my physician(s) at this facility, including separate charges by independent contractors (such as emergency department physicians, radiologists, psychologists and anesthesiologists). I guarantee full payment of all charges unless restricted by Medicare or Medicaid. These charges include, but are not limited to, services to screen, and, if necessary, stabilize an emergency medical condition. I understand that I may receive more than one bill for the care I receive at this facility because my physicians or other independent medical and allied health care providers may bill for their professional fees separately from each other and separately from the facility's set and established charges, facility fee, and/or technical fee. The facility fee or technical fee is charged for such things as nursing, technician, and housekeeping support, medical records administration, and the use of equipment, technology and routine supplies. I also understand that depending on my insurance coverage and deductible amounts, the facility fee could increase my out-of-pocket costs. Additionally, I understand that the physicians and other independent medical and health care providers may be contracted with insurance companies that differ from the facility. Thus, my financial responsibility may be greater for services received, and if I have any questions about my benefits coverage, I will contact my insurance company directly.

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Assignment of Benefits: I hereby assign all of my rights and benefits under my existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the facility, affiliated physicians, and/or other independent contractors and authorize direct payment to these parties for such services and treatment. I understand that most health insurance policies, including Medicare and Medicaid, are secondary payers to any existing liability policies, no-fault insurance, workers compensation or any other sources of payment that may or will cover expenses incurred for services and treatment.

I hereby appoint the facility, affiliated physicians, other independent contractors, and any agent acting on their behalf as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for the collection against any responsible payer or third party liability carrier of any and all benefits due me for the payment of charges associated with my treatment.

Consent to Electronic Surveillance: The facility reserves the right to implement policies for purposes of promoting the safety and security of the facility, its patients, visitors, employees and medical/professional staff. I understand and agree that the facility may engage in electronic surveillance in public areas, and that I may be photographed, videotaped, audiotaped or have digital or other images (audio, video, or both) (collectively referred to as “Images and/or Other Recordings”) of me recorded while public areas of the facility. I further understand that these Images and/or Other Recordings will be accessed and stored in a secure manner that will protect my privacy to the greatest extent possible and that they will be maintained and stored in accordance with facility policies.

Photography, Video, Audio Recordings, and Other Imaging: I understand photographs and recordings may be taken of me during my care for purposes of identification, diagnosis and treatment. I further understand recordings or photographs that do not include personally identifiable information may be used internally for educational and teaching purposes. Unless required by law, the use or release of photographs and recordings for any other purpose requires my express written consent.

Communication Concerning Services and Debt Collection: I authorize this facility to communicate with me for any reason related to the provision of services, including collection of amounts owed for services, using text messaging services, an automatic telephone dialing system or prerecorded voice at the telephone number(s) I provided, including a telephone number assigned by a cellular telephone service or any service for which I am charged for the call. In addition, I consent to and agree that any calls between this facility and I may be monitored and/or recorded for any purpose. If debt collection becomes necessary, I also authorize this facility, including any collection agency or debt collector hired by this facility, to check my credit and employment history, obtain a copy of my consumer report and obtain personal information from any consumer reporting agency.

Acknowledgement and Certification:
By signing this form, I certify that I am the patient or the patient’s legal representative, I have read this Conditions of Treatment form, I was given the opportunity to ask questions, and I understand and accept all terms herein.

_______________________________________ OR _______________________________________

Patient’s Signature *Date/Time* *Signature/Relationship* *Date/Time*
(Parent/Legal Guardian/Responsible Person)

_______________________________________ OR _______________________________________

Witness’ Signature *Date/Time* *Second Witness’ Signature* *Date/Time*
(If Oral/Telephone/Patient Mark)

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Signature of Guarantor *Date* *Please Print Name*