Samaritan Health Services

# Conditions of Admission

Place Patient Label Here

**MEDICAL AND SURGICAL CONSENT:** I consent to the care, treatment and procedures which may be performed during this **inpatient hospitalization, observation, outpatient surgery or emergency visit.** My practitioner will inform me of recommendations related to my treatment that may include tests, examinations or surgery and I reserve the right to refuse any recommended procedure or treatment. I am aware that I may be photographed or videotaped to document my treatment or care in my medical record. All such photographs and videotapes are confidential. IF THE PATIENT IS A MINOR (UNDER 15 YEARS OF AGE) OR LEGALLY INCOMPETENT TO SIGN FOR HIS/HER OWN MEDICAL CARE, THE PARENT OR LEGAL GUARDIAN MAY SIGN IN HIS/HER PLACE.

**RELEASE OF SPECIALLY PROTECTED INFORMATION:** A separate authorization will be required for release of the following information: HIV positive diagnosis, drug/alcohol addiction program records, psychotherapy notes and/or mental health program records.

**PHYSICIANS:** Professional services rendered by independent contractors are not part of the hospital bill. These services will be billed to the Patient separately. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

**RELEASE OF INFORMATION:** I authorize SHS to release information from my medical records to any insurance carrier or government agency for the purpose of processing my claims for health care services.

**OBSERVERS/STUDENTS/RESIDENTS:** SHS locations provide clinical experience for various educational programs. I understand that students or health care practitioners may observe or participate in my care as part of the educational programs authorized by this facility.

**PERSONAL PROPERTY:** I agree that SHS is not responsible for loss or damage to any valuables or personal items (including glasses, dentures, hearing aids, contact lenses, personal electronic devices, and cell phones). I understand that SHS hospitals have accommodations for keeping money, jewelry, documents or other valuables upon request. I understand that any personal property not claimed within 30 days of my discharge will be disposed of according to SHS policy.

**FINANCIAL AGREEMENT:** I understand that I am financially responsible for charges not covered by insurance. I also understand that I am responsible for paying deductibles, co-insurance and co-pays. I agree to make payment according to SHS credit policies. In order to avoid a finance charge, all charges accrued must be paid in full within 90 days of the first statement's closing date. I also understand that credit balances of less than $10.00 will be refunded by request only and if the refund check in the amount of $20 or less is not cashed, I will forfeit the amount as a service charge (ORS 98.311).

**INSURANCE BENEFITS ASSIGNMENT:** The information I have supplied is true and accurate to the best of my ability. I direct and assign all insurance companies, health care service plans, and other third party payers to make payment directly to SHS.

**MEDICARE CERTIFICATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act or Medicaid is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize them to submit a claim to Medicare for payment to me.

**CONSENT FOR BLOOD TESTING:** I consent to have my blood tested for HIV and Hepatitis antibodies in the event a SHS health care worker or other person has an accidental exposure to my blood and/or body fluids. I understand that I can obtain the results of these tests from my physician who can explain them to me. I understand there will be no cost to me for the testing.

**Opt-Out Statement**

☐ I DO NOT give permission to have my blood tested for HIV and Hepatitis antibodies in the event a SHS health care worker or other person has an accidental exposure to my blood and/or body fluids.

**PATIENT RIGHTS ACKNOWLEDGEMENT:** I have reviewed a copy of Patient Rights and Responsibilities and the Notice of Privacy Practices and understand I can obtain a copy upon request.

Patient or Patient's Representative

Relationship to the Patient

Witness

Date/Time