Patient Name:_____ Date of Birth:_____

Consent for Admission and Registration

CHI St. Joseph Health

INTRODUCTION: CHI St. Joseph Health is hereinafter referred to as "the Hospital." Any and all Physicians providing care and treatment including consultation during the course of my admission to the Hospital are hereinafter referred to as "the Physicians."

1. CONSENT TO TREATMENT: I have a condition requiring examination, diagnosis, and treatment and hereby consent to and authorize such customary care including but not limited to x-ray, laboratory, routine diagnostic tests and therapeutic procedures ("Services") performed by my admitting and treating Physician, which may or may not be employed by the Hospital and his or her assistants or designees, including personnel employed by the Hospital. I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this and for the Hospital to retain ownership rights to these images. A separate consent for photography form will be obtained for disclosure of any images outside of the Hospital that identify me and are used for purposes such as education and marketing. I agree to the supervised participation of health care students (e.g., medical students, nursing students, interns, residents, and non-Physician clinical students) in my care. I understand that such care may involve risks and that no guarantees have been made to me concerning the results of this treatment or examination. I further understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures/treatment. For any notice or authorization referenced herein, a copy of this form can be used in place of the original.

2. ASSIGNMENT OF BENEFITS: The undersigned authorizes, whether he/she signs as agent or as Patient, billing by and direct payment to the Hospital (or to the Physicians providing Services to the Patient at Hospital and who do hereafter accept such assignment and bill directly for their Services) of any insurance benefits (as defined below) and any governmental program benefits otherwise payable to or on behalf of the Patient or the undersigned for this Hospitalization (including Physician Services attributable to this Hospitalization) or for these outpatient Services, including emergency Services if rendered, at a rate not to exceed the Hospital's (or Physician's) regular charges. The term "insurance benefits" as used herein includes all insurance benefits including but not limited to health insurance, accident, worker's compensation benefits and motor vehicle insurance, casualty insurance, medical health coverage and uninsured or underinsured insurance. It is understood by the undersigned that he/she is financially responsible for all charges. In consideration of goods and Services provided, he/she gives Hospital an irrevocable assignment to any and all rights, title and interest he/she has in all insurance benefits or governmental program benefits payable to him/her or in his/her behalf for Services provided by Hospital, Physician or their employees and others working under an arrangement with the Hospital (or its Physicians). He/she directs all insurance companies, health plans, governmental agencies and programs and their agents or contractors, and attorneys to make such payment directly to Hospital (or to such Physicians at the address specified in billing invoices). Any credit balance resulting from benefit payments or other sources may be applied to any other account owed by the Patient or the undersigned.

3. FINANCIAL RESPONSIBILITY: I understand that if my Insurer denies all or any part of Hospital's charges for any reason, or if I have no insurance, I will be personally and fully responsible for payment of Hospital's charges. I agree, whether I sign as the Patient, Legal Representative, or Guarantor for the Patient, that in consideration of the Services rendered that I individually obligate myself and/or the Patient to pay the account of Hospital in accordance with the established rates and payment policy of the Hospital. If I believe I qualify for financial assistance, I must notify the business office. The undersigned authorizes the transfer of any overpayment on this account to be applied to any account which the undersigned is a patient, guarantor, or otherwise legally responsible.

4. PRE-ADMISSION CERTIFICATION AND RELEASE OF INFORMATION: I authorize payment of my insurance benefits to the physicians and Hospital named on my insurance claim form. I further authorize release of information required by any Insurer or third-party payor regarding any claim made relating to me. I understand that I am financially responsible for charges not paid by my insurance company and/or third party payor. I understand that it is my responsibility to provide notice to and to obtain pre-admission certification from any Insurer or third-party payor if required under the terms of my relationship with an insurance carrier or any third party payor. I will be personally responsible for all or part of the cost of hospitalization or professional Services if payment of the same is denied by reason of my failure to provide notice or obtain certification or authorization.

5. CERTIFICATION/AUTHORIZATION FOR MEDICARE OR MEDICAID BENEFITS: I certify that the information given by me in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act or under any other governmental health care program or from any other third-party payor is correct. Furthermore, I authorize anyone having medical or other information about me pertinent to my qualification for Medicare or Medicaid programs or benefits to release to and to secure from the Social Security Administration, the State Medical Assistance Program or to other agencies or entities administering the Medicare and Medicaid programs, or to intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf directly to the Hospital, to the Physicians, and to any other health care provider qualifying for reimbursement for such medical care and treatment, including consultations, provided to me.

6. AUTHORIZATION FOR THE RELEASE OF INFORMATION: I authorize the Hospital to release to any person, corporation, or any other entity any diagnostic therapeutic information including any diagnosis and treatment involving ALCOHOL AND SUBSTANCE ABUSE COUNSELING, BEHAVIORAL OR MENTAL HEALTH SERVICES, GENETIC TESTING, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV status, as applicable, and as may be necessary to determine health care benefits entitlement for me under any insurance policy or other type of health care benefits plans or as may be appropriate for the purpose of analysis or research regarding reimbursement of Physicians and other health care providers. I authorize the Hospital to process payment claims for health care Services provided. I agree to cooperate and execute such other authorizations and releases for the above purposes as deemed necessary by the Hospital upon the Hospital's request. I understand the Hospital may utilize information in my medical record that is necessary for research or quality improvements purposes.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from re-disclosing information protected by law to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that this revocation will not apply to the extent that Hospital has already taken action in reliance on this authorization. This authorization is valid until all terms and conditions, including payment of this admission are met.

I understand that authorizing the disclosure of this health information is voluntary. I understand I can refuse this release as it does not assure treatment, payment, enrollment or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in 42 CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the medical records department at (979) 776-2524.

_____	_____	_____
Patient or Legal Representative Signature	Printed name & relationship of person signing on behalf of patient	Date

7. INDEPENDENT STATUS OF PHYSICIANS: I recognize that not all Physicians, and health care providers including, but not limited to, Certified Registered Nurse Anesthetists, Radiologists, Emergency Room Physicians, Anesthesiologists, Physical, Occupational and Speech Therapists, residents or medical students (under the supervision of Physicians and/or residents) who provide Services to me during this admission are employees or agents of the Hospital. Such individuals are INDEPENDENT CONTRACTORS who are granted privileges to use the Hospital for private Patients and bill separately for their Services. In addition, I understand that the Hospital is not responsible for nor does it assume any liability for the acts or omissions of any such independent contractors.

8. TESTING FOR INFECTIOUS DISEASES: I understand that, if testing for Human Immunodeficiency Virus ("HIV") or any other blood borne infectious disease is ordered by a Physician for diagnostic purposes, I will be asked to sign a separate written informed consent. I also understand that, in the case of exposure of a health care provider or first responder (such as an emergency worker, fire fighter or police officer) to my bodily fluids, although I will be informed of the right to consent to testing for HIV or other infectious diseases transmitted by bodily fluids, in most cases, tests may be performed on previously gathered bodily fluid samples or a court order may be obtained to compel such testing. Information concerning the fact that a test was ordered and the results of such test will remain confidential and be disclosed by the Hospital only as permitted by law**.**

9. PERSONAL EQUIPMENT AND VALUABLES: I understand that the Hospital does not accept responsibility and will not reimburse me for the loss of money, jewelry, eyewear, hearing aids, dentures, clothing or other personal property or valuables which I bring to the Hospital. I take full responsibility for such items and agree to release the Hospital from any and all liability from damage, loss or theft of such items unless, as applicable, the items are deposited in the Hospital safe for safekeeping. I also understand that I must inform the admissions clerk or a nurse if I bring any electrical equipment to the Hospital (e.g. ventilators; Bipap machine, Cpap machine) and adhere to Hospital policies regarding its use. I assume full responsibility for such electrical equipment and for any injury caused by the use of the electrical equipment brought from home.

10. SEMI-PRIVATE AND PRIVATE ACCOMMODATIONS DIFFERENTIAL: I understand that Medicare and other payers do not pay the difference in the cost between a private and semi-private room when use of a private room is not ensured by medical necessity for isolation purposes. If I request a private room at any time during the Hospital stay, I, hereby agree that the difference in the cost between a semi-private and private room will be my responsibility to pay.

11. WORKER'S COMPENSATION AUTHORIZATION: If my admission to the Hospital is a result of a work related injury, I hereby waive any privilege I may have with the Hospital, or other healthcare provider, and I hereby authorize these providers to provide the worker's compensation administrator, any information, including, but not limited to, the right to inspect and copy all of my medical records related to my injury or to my past relevant medical history. In the event there is a dispute about the compensability of my claim or worker's compensation benefits, and if my employer is not specifically determined by a Court of the Department of Labor to be responsible for worker's compensation medical expenses for the condition or injury that is the basis of my admission, I agree to be personally responsible for all such expenses. I further agree that if my worker's compensation claim is settled with my employer on a disputed basis without a specific finding that such is compensable as a worker's compensation injury, I (or my attorney if I am represented), will withhold sufficient funds from any settlement to pay all amounts owed to the Hospital for treatment of the condition which is the basis for this admission and I hereby grant an assignment to the Hospital for payment of all such expenses under such circumstances.

12. GENERAL DUTY NURSING: Except in the special care units, the Hospital provides only general nursing care. The Patient and/or Representative should consult with the Patient's attending Physician(s) to determine if the Patient's condition requires continuous or special duty nursing care. If so, such special duty nursing care must be arranged by the Patient, or Legal Representative and the Hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability from failure to provide special duty nursing care and from any liability arising from any acts or conduct of anyone providing special duty nursing care.

13. COMMUNICATIONS CONSENT: By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from Hospital, its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving healthcare services.

14. PHARMACY HEALTH INFORMATION EXCHANGE: I consent to Hospital to obtain my medication history information electronically through a pharmacy health information exchange (e.g., Surescripts, E-Prescribe). Physicians and providers access the information to know what medications I am taking so that they can treat me appropriately and avoid adverse drug reactions.

Advance Directive: An Advance Directive allows you to tell your physician or give someone else the authority to tell your physician what kind of care you would like to receive if you become unable to make medical decisions for yourself.

Do you have an advance directive? ___ Yes ___No

If Yes:	**If No:**
Have you provided a copy to the Hospital? ____ Yes ____ No Please indicate which type(s) of directive you have provided: _____ Directive to Physicians / Living Will _____ Out-of-Hospital DNR Order _____ Medical Power of Attorney _____ Declaration for Mental Health Treatment	Would you like to receive information to formulate an Advance Directive? _____ Yes _____ No **If Yes, information given:** _____ Yes _____ No

Patient Name:_____ Date of Birth:_____

Directory Information Disclosure: I, the undersigned, understand that should I/the patient be hospitalized, that information about my/the patient's health care is kept in my/the patient's medical record and is kept private.

Please choose and initial by one of the following options:

Option A: _____ I authorize the Hospital to use the following information to maintain a directory of individuals in the Hospital: my name, my location in the Hospital, my condition (as described in general terms such as critical, poor, fair, good or excellent), and my religious affiliation. I authorize the Hospital to disclose such information to members of the clergy or to persons who ask for me by name (with the exception of my religious affiliation).

Option B:_____ NO INFORMATION / NO DISCLOSURE: I do not want anyone to know that I am a patient in this facility. I do NOT authorize release of any information regarding my admission or treatment. **I understand that mail, flowers, visitors and phone calls will be refused on my behalf. I understand that friends and family will not be allowed to visit me.**

Patient Identification Number: I further understand that the Hospital has a policy to allow the release of patient related medical information and updates **DURING CURRENT HOSPITALIZATION ONLY** to individuals authorized by the patient to receive this information. For this purpose, a **Patient Identification Number (PIN)** is available to the patient who can decide to share this number at his/her discretion with family and/or friends so the Hospital staff can share information about patient location and condition with those designated by the patient who have been provided the PIN information. Otherwise, the information will be restricted to those individuals who do not have the PIN information.

REPRESENTATION/SIGNATURE: My signature below indicates that I have read fully and understand this document or have had it read to me and that I (As the Patient or the Patient's Legal Representative, or Guarantor) hereby accept and agree to the terms of this Conditions on Admission.

Check all that apply prior to signature.

☐ I received a copy of the Rights & Responsibilities of Patients.
☐ I received the Important Message from Medicare

AM / PM

Signature of Patient, Legal Representative or Legal Guarantor — Date — Time

If other than Patient, Relationship of above Signatory to Patient — Reason, if other than Patient (Incompetent, Minor, ect.)

Witness Signature

Interpreter Name/Number (if applicable)

Hospital does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or providing Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received a copy of the Hospital's Notice of Privacy Practices and have indicated so by signing here.

Signature of Patient /Legal Representative/Guarantor — Date

OR

* The undersigned certifies that he or she provided a Notice of Privacy Practices to the Patient, but that the Patient either was unable to or unwilling to acknowledge receipt of such Notice of Privacy Practices for the reason noted below.

Name of Hospital Representative Seeking Acknowledgement* — Date

Reason for Lack of Acknowledgment: _____

PATIENT RIGHTS
I acknowledge that I have been given information and instructions regarding my Patient Rights. My Patient Rights include, but are not limited to, the right to make medical decisions, including the right to accept or refuse medical treatment, participate in my plan of care and receive care in a safe setting, free from verbal or physical abuse or harassment. I also understand that if I have questions regarding my rights, I should ask an employee of this facility for assistance.
Patient's Bill of Rights:

I, as the patient, have a right to:

- receive reasonable access to care and treatment that is medically indicated as necessary and within the facility's capability and mission, regardless of race, creed, sex, age, national origin, or sources of payment for care;
- receive considerate, respectful care at all times and under all circumstances, with recognition of personal dignity;
- be free from all forms of abuse or harassment;
- be free from restraints and seclusion in any form when used as a means of coercion, discipline, convenience for the staff, or retaliation;
- personal and informational privacy, within the scope of the law;
- expect that a family member or representative of my choice and my own physician will be notified promptly of my admission to the facility;
- the presence of a support individual of my choice, unless the individual's presence infringes on others' rights, safety, or is medically or therapeutically contraindicated;
- designate visitors subject to limitations that are clinically necessary;
- expect reasonable safety insofar as the facility practices and environment are concerned and request additional assistance when I have a concern about my condition;
- know the identity and professional status of individuals providing service;
- obtain, from the practitioner responsible for coordinating care, complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis;
- means of communication with people outside the facility by means of visitors and by oral and written communication in my preferred language for discussing healthcare, and by access to an interpreter if language barriers exist;
- reasonably informed participation in decisions involving health care and receive information about experiments, research, or educational projects affecting my care and treatment; the patient has the right to refuse to participate in any such activity.
- consult with a specialist at my own request and expense;
- accept or refuse medical care to the extent permitted by law;
- receive an explanation if being transferred to another facility;
- request and receive an itemized and detailed explanation of my total bill for services when available;
- be informed of facility rules and regulations applicable to my conduct as a patient;
- participate in the consideration of ethical issues that arise during my care;
- formulate advance directives and appoint a surrogate to make health care decisions on my behalf as described above;
- receive appropriate assessment and effective management of pain.

I have the responsibility to:

- provide accurate and complete health information and to understand my plan of care;
- follow the plan of care developed by me and my healthcare team;
- accept responsibility for the outcomes of refusing treatment or for not following my agreed upon plan of care;
- fulfill my financial obligations;
- be considerate of the rights of others and follow the rules and regulations of this facility about patient care and conduct.

Signature of Patient /Legal Representative/Guarantor Date