HOAG ORTHOPEDIC INSTITUTE

CONDITIONS OF ADMISSION

The undersigned patient is admitted to Hoag Orthopedic Institute ("Hospital") for inpatient and/or outpatient treatment subject to the following terms and conditions:

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURE
   The undersigned consents to the procedures that may be performed during this hospitalization or on an outpatient basis, which may include, but are not limited to, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon. In order to meet the requirements of California law, assessments and tests may be performed or treatment rendered during the Hospital stay for the welfare of the patient. The undersigned consents to such testing or treatment done pursuant to state law.
2. NURSING CARE
   Hospital provides only general duty nursing care and care ordered by the patient's physician(s). 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 patient's legal representative. 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 the patient is not provided with such additional care.
3. PHYSICIANS ARE INDEPENDENT MEDICAL PRACTITIONERS
   All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, hospitalist, and the like, are independent medical practitioners and are <u>not</u> employees or agents of the Hospital. They have merely been granted the privilege of using the Hospital for the care and treatment of their patients. Fees for physician services are billed separately from Hospital charges, and, therefore, the patient may receive multiple bills.

   Initial Here: _____

   The patient is under the care and supervision of the patient's attending physician. The Hospital and its nursing staff are responsible for carrying out the instructions of the patient's physician(s). 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.
4. PERSONAL BELONGINGS
   The patient is encouraged to leave personal items at home. The Hospital maintains a fireproof safe for the safekeeping of money and valuables. The Hospital is not liable for the loss or damage to any money, jewelry, documents, or other personal property items, valuables or belongings that are not placed in the safe. The Hospital's liability for loss of any personal property deposited with the Hospital for safekeeping is limited by law to a maximum of five hundred dollars ($500) unless a written receipt for a greater amount has been obtained from the Hospital. The undersigned agrees to these terms and conditions.

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5. PARTICIPATION IN MEDICAL EDUCATION / TEACHING PROGRAMS
   The undersigned acknowledges and understands that the Hospital participates in teaching programs and as such the training of physician fellows through a Medical Education Program, nurses and other health care personnel takes place at the Hospital and these individuals may participate in the operation, special diagnostic or therapeutic procedures, or treatment specified above under appropriate supervision.
6. CONSENT TO PHOTOGRAPH FOR TREATMENT PURPOSES
   The undersigned consents to the taking of photographs (including still images, video or film, digital imaging or other format or means of recording or reproduction) of the patient's medical or surgical condition or treatment while receiving treatment at the Hospital, for the purpose of the patient's diagnosis or treatment or for the Hospital's operations, such as peer review or medical education.

7. FINANCIAL AGREEMENT

The undersigned, whether signing as patient or the patient's agent, agrees that in consideration of the services to be rendered to the patient, they hereby individually obligate themselves to promptly pay all Hospital bills in accordance with the charges listed in the Hospital's charge description master, and with the regular rates and terms of the Hospital, including its financial assistance policies, if applicable. The undersigned understands that all physicians and surgeons, including the radiologist, pathologist, anesthesiologist, hospitalist, and others, will bill separately for their services. Should any account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

8. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned, whether signing as patient or patient's agent, irrevocably assigns and transfers to the Hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for patient's care. This assignment includes assigning and authorizing direct payment to the Hospital of any insurance and health plan benefits payable to or on behalf of the patient for this hospitalization or for these outpatient services. It is agreed that payment to the Hospital, pursuant to this authorization, by an insurance company or health plan shall discharge its obligations to the extent of such payment. It is understood that the undersigned is financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. The undersigned agrees to cooperate with, and take all steps reasonably requested by, the Hospital to perfect, confirm or validate this assignment.

9. HEALTH PLAN (INSURANCE) OBLIGATION

Hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the Admitting and Registration Office. The Hospital has no contract, express or implied, with any plan that does not appear on the list. It is the patient's obligation to assure that the patient's health plan has authorized the services to be provided by the Hospital. The undersigned agrees that they are individually obligated to pay all Hospital bills in accordance with Section 7 above if the patient belongs to a plan which does not appear on the above-mentioned list or if the services provided are not covered under the patient's plan. All physicians and surgeons, including the radiologist, pathologist, anesthesiologist, hospitalist, and others, will bill separately for their services. It is the responsibility of the undersigned to determine if physicians providing services to the patient contract with the patient's health plan, if any.

10. ACKNOWLEDGMENTS

a. The undersigned acknowledge that they have received the Patient Information brochure which addresses Patient Rights and how to file a grievance, Patient Responsibilities, and Your Right to Make Decisions about Medical Treatment (Advanced Health Care Directive information) among other information.

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b. The undersigned acknowledges and understands that the Hospital may provide services to its patients through the use of outside resources or under arrangements with third parties, including, for example, services provided to Hospital patients by Hoag Memorial Hospital Presbyterian. In these circumstances, the Hospital retains professional and administrative responsibility for all services provided to its patients by these outside resources. Initial Here: _____

c. The undersigned hereby requests and agrees that the patient's test results be provided to the Patient Portal so that patient may access them electronically as part of the clinical health record. The undersigned understands that the laboratory test results made available through the Patient Portal will not include the test results for HIV, hepatitis, drug abuse, or a malignancy. ☐ YES ☐ NO Initial Here: _____

11. NOTICE OF PHYSICIAN FINANCIAL INTEREST

The undersigned acknowledges that they have been advised that the Hospital meets the definition of a "physician owned hospital" as defined by federal law (42 C.F.R. 489.3), and that a list of the Hospital's owners/investors, who are physicians or immediate family members of physicians, is available upon request. The undersigned acknowledges receipt of the Hospital's "Disclosure of Ownership" notice and understands that the patient has the option to choose a facility other than the Hospital for services requested or ordered by patient's physician. Initial Here: _____

12. CALIFORNIA IMMUNIZATION REGISTRY

Hospital may share your immunization or tuberculosis (TB) screening test records with the California Immunization Registry (CAIR), a statewide, secure and confidential database of patient immunization information. The CAIR is used by health care professionals, agencies, and schools to keep track of all shots and TB tests you take and can provide proof about immunization needed to start childcare, school, or a new job. If you do not want your immunization or TB records to be shared with other registry users, please fax or email the "Decline or Start Sharing/Immunization Information Request Form," available on the CAIR website at http://cairweb.org/cair-forms/, to the CAIR Help Desk at 1-888-436-8320 or CAIRHelpDesk@cdph.ca.gov. Initial Here: _____

13. TELEPHONE CONSUMER PROTECTION AND CAN-SPAM ACTS

By providing a telephone number (including a landline or a wireless phone number), the undersigned consents to receive calls at this number from the Hospital, its agents, representatives and independent contractors (including service providers and collections agencies) regarding Hospital services and any related financial obligations, which may result in charges to the undersigned. The undersigned expressly consents that methods of contact may include using pre-recorded and artificial voice messages and/or the use of automatic dialing device, as applicable. This consent applies to all services and billing associated with the patient's account number(s) and is not a condition of purchasing property, goods, or services. You are not required to initial this section as a condition of admission.

If Opting Out, please check: ☐ Initial Here: _____

The undersigned certifies that they have read the Conditions of Admission, received a copy, and that they are the patient, the patient's legal representative, or otherwise duly authorized by the patient to sign the above and accept its terms on the patient's behalf.

Signature of Patient/Legal Representative: _____ Date: _____ Time: _____A.M./P.M.

If signed by other than the patient, indicate relationship: _____

Hospital Representative: _____

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 Plan Obligation provisions above.

Signature of Financially Responsible Party: _____ Date: _____ Time: _____A.M./P.M.

Hospital Representative: _____

Interpreter's Statement: The foregoing document was translated by the interpreter (listed below) to the patient or legal representative in the patient's or legal representative's primary language (indicate language):_____. He/she understood all of the terms and conditions and acknowledged his/her agreement with the above document.

Interpreter Name and Identification Code – Print: _____ ☐ Interpreter Service

Witness: _____ Date: _____ Time: _____A.M./P.M.

Patient Identification