

## ADMISSION AGREEMENT

**If you have any questions about this document or do not understand any portion of it, or need an interpreter, ask your physician or other health provider.**

Name of Patient: \_\_\_\_\_

Name of Attending Physician(s): \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Time: \_\_\_\_\_ (a.m.) (p.m.)

I, \_\_\_\_\_, hereby  
(Name of patient or Name of authorized representative acting on behalf of patient)  
consent to the rendering of such care and treatment as the named attending physician(s) and other physicians who may attend to me consider to be necessary and as may be administered or rendered by this facility, its staff, employees, agents and students.

I acknowledge the care I receive while in the facility is under the direction of my physician(s). This facility is not responsible for the acts or omissions of my physician(s).

I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination or treatment in this facility.

I understand that many of the physicians on the staff of this facility, including the attending physician(s) named above, may not be employees or agents of the facility, but, may be independent contractors who have been granted approval to use the facility for the care and treatment of their patients. Further, I realize that there may be medical, nursing and other health care personnel in training who, unless requested otherwise, may be present during patient care as a part of their education. Photographs, video or other electronic imaging may be used for educational purposes, unless a patient expressly requests otherwise.

## **RELEASE OF INFORMATION**

I hereby acknowledge that this facility and my treating physician may release, by electronic means or otherwise, any medical information concerning my care, including copies of my medical records, to the following:

- any health professionals involved in my care for the purpose of facilitating the continuity of my medical care
- any person or entity responsible for, or any person or entity acting as agent for, the party responsible for payment, including third party payors, self-insurers, worker's compensation carriers and governmental agencies, payment for the medical services rendered to me at the facility by employees of the facility or any person providing services at the facility or any affiliate
- any federal, state or other governmental or quasi-governmental agencies or other such parties as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs
- any person or entity participating in quality studies, utilization review or similar studies of the care rendered by the facility, affiliates and/or their physicians
- the supplier of any blood or blood products which may administered to me for the purposes of quality control and recipient monitoring
- any continuing care, residential, or long-term facility, or home health agency for the purpose of providing services for my care

## **PATIENT RIGHTS**

I acknowledge receipt of the patient rights information explaining my rights as a patient of this facility.

## **ADVANCE DIRECTIVES**

I acknowledge that I have been asked if I have an advance directive and have been informed of my right to make medical decisions, my right to make an advance directive pursuant to state law, the facility's policy concerning honoring advance directives and my right not to be discriminated against based on whether I have an advance directive.

Patient  
initials  
\_\_\_\_\_

## **VALUABLES/PATIENT RESPONSIBILITY**

I have been advised to leave valuables at home (or deposit valuables in the facility's safe) during hospitalization. Should I choose not to do so, I assume all responsibility for the

loss of, or damage to, any personal property including money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, documents, luggage or any other items during my stay.

**PAYMENT FOR MEDICAL AND RELATED CARE**

I agree to pay the facility and physicians for all services rendered at this facility. Many physicians furnishing services to the patient are independent contractors and are not employees or agents of this facility. Consequently, I understand that I may receive a separate bill for their services. If the requirements for referral, second opinion or pre-certification of care as outlined by my insurer, benefit plan or other payor, have not been followed, I, as patient and/or guarantor, may in some instances be personally responsible for all charges incurred.

**ASSIGNMENT OF BENEFITS**

I hereby authorize and assign payment to this facility of any type of reimbursement or payment due from Medicare, Medicaid or any other third party payor, for any and all cost incurred for my medical and related care at this facility and/or by the independent contractors providing services at this facility.

**NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of this facility's notice of privacy practices that explains this facility's use and disclosure of any protected health information.

Patient  
initials  
\_\_\_\_\_

THIS FORM HAS BEEN FULLY EXPLAINED TO ME, AND I AM SATISFIED THAT I UNDERSTAND ITS CONTENT AND SIGNIFICANCE.

**OR**

\_\_\_\_\_  
*Patient's Signature*

\_\_\_\_\_  
*Date/Time*

\_\_\_\_\_  
*Date/Time*

\_\_\_\_\_  
*Signature/Relationship*

*(Parent/Legal Guardian/Responsible Person)*

\_\_\_\_\_  
*Witness' Signature*

\_\_\_\_\_  
*Date/Time*

\_\_\_\_\_  
*Date/Time*

\_\_\_\_\_  
*Second Witness' Signature*

*(If Oral/Telephone/Patient Mark)*

\_\_\_\_\_  
*Signature of Guarantor*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please Print Name*