

住院同意書

ADMISSION AGREEMENT

若您對這份文件內容有任何疑問或不了解的部份，或者需要口譯員，請向您的醫師或相關醫療人員詢問。

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.

病人姓名： _____

Name of Patient: _____

主治醫師(們)姓名： _____

Name of Attending Physician(s): _____

入院日期：西元____年____月____日； 時間：上午/下午____點____分

Date of Admission: _____ Time: _____ (a.m.)
(p.m.)

我, _____, 特此同意我的主治醫師(們)和其它參與治療
(病患姓名或病患授權的代理人的姓名)
的醫師們，提出可能認為是必需的、且藉由這樣的機構、醫療服務人員、工作人員、代理人以及學生所提供的醫療照顧。

I, _____,
(Name of patient or Name of authorized representative acting on behalf of patient)

hereby 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.

我公開承認在此機構所獲得的醫療照顧是在我的主治醫師指示下執行的。此機構並不必要對我的主治醫師(們)的醫療行為或疏忽負責任。

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).

我理解內科與外科的治療不是精確無誤的科學，並且在診斷與治療過程可能會造成傷害或甚至死亡的危險。我公開承認在此機構中對我所作的檢查與治療的結果是無法保證的。

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.

我了解此機構的醫生與工作人員，包括參與我治療的主治醫師(們)，可能不是此機構僱用的員工或代理人。但是可能已經經過許可與簽訂正式合約以使用設備做為病人的照顧與治療的獨立簽約者。更進一步，我了解除非在特別要求下，可能會有正在接受訓練的醫師、護理人員或醫事人員在治療過程中在場以作為教育的一部份。若無特別聲明，醫療過程中的照片、錄影帶、或電子影像檔案將可能會使用作為教育目的。

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.

資料的公開許可

RELEASE OF INFORMATION

我特此公開承認此機構與我的主治醫師可以將與我的護理有關的醫療訊息，包括病歷紀錄影本，藉著電子傳送或其他方式傳遞給以下機構或相關人員。遵守下列：

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:

- 任何參與我的看顧的醫療專業人員，目的在於促進對我持續醫療照顧的進行。
- any health professionals involved in my care for the purpose of facilitating the continuity of my medical care
- 任何對我醫療服務費用負責的人或團體，或此負責人的代理人或任何團體的代理人，包括第三方償付者、自費的保險人、勞工補助金管理者、政府機關或任何人或實際參與的，以作為此機構或相關機構申請醫療費用的依據。
- 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
- 任何聯邦的、州立的、或其他政府的、或準官方的機構、或其他部門，被法律要求依此作為報導的目的或作為決定政府社會福利補助計劃資格之依據。
- 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
- 任何一個人或團體參與品質研究、醫療利用率審查或機構、機構聯盟及/或他們的醫師們提出的類似的研究。
- 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
- 輸血或血液產品的供應廠商，用以進行產品質量控制與接受監控。
- the supplier of any blood or blood products which may administered to me for the purposes of quality control and recipient monitoring
- 任何持續照護、住民的、或長期照護機構或居家(家居)照護機構，以作為提供對我服務的目的
- any continuing care, residential, or long-term facility, or home health agency for the purpose of providing services for my care

病人的權利

PATIENT RIGHTS

我公開承認我已經收到身為該機構的病人權利的解釋說明。

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

進一步的詳細指示

ADVANCE DIRECTIVES

我公開承認我已經被詢問是否我有一個進一步的詳細指示；並且我已被告知我有作醫療決擇的權利。和我有做更具體指示的權利，以符合州法令、機構政策尊重我的進一步的詳細指示擬定一份進一步的詳細指示；及根據不論我是否有進一步的詳細指示，我有不受歧視的的權利。

病人的姓名字首的縮寫

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

貴重物品/病人責任

VALUABLES/PATIENT RESPONSIBILITY

我已經被告知住院期間將貴重物品留在家中(或放在機構內的保險箱中保管)，這些物品包括金錢、信用卡、衣服、珠寶、眼鏡/隱形眼鏡、假牙(牙套)、助聽器、文件、行李箱或其他的物品。萬一我沒有依照規定，我願意承擔住院期間的一切損失責任。

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.

醫療和相關護理費用

PAYMENT FOR MEDICAL AND RELATED CARE

我同意付費給提供所有服務的機構和醫師。若提供服務的醫師是獨立簽約而非機構內員工或代理人，我知道我可能會收到他們服務的個別帳單。假若來自於我的投保人，福利計畫或其他付費人的，要求提供護理的參考，第二意見，和前期證明的請求沒有被送到。我，身為病人和/或保證人，在某些情況下負責所有引起的收費。

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.

費用的支付

ASSIGNMENT OF BENEFITS

我在此簽字授權並轉讓各種在此機構與此機構有合約之簽約個人所申請的與我的醫療和護理相關的醫療費用給此機構；這些費用的來自聯邦醫療保險及醫療補助 (Medicare、Medicaid)、或任何其他第三方支付者。

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.

隱私權實行的通知

NOTICE OF PRIVACY PRACTICES

我特此公開承認我已經收到一份此醫院的隱私權實行的通知；該通知解釋此機構如何利用與公佈任何受保護的健康資料。

病人的姓名字首的縮寫

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

我完全地滿意這份文件的詳細解說，並且我了解它的內容與重要性

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

或

病人的簽名

日期/時間

簽名/關係

日期/時間

(父母/合法監護人/負責人)

OR

Patient's Signature

Date/Time

Signature/Relationship

Date/Time

(Parent/Legal Guardian/Responsible Person)

證人的簽名

日期/時間

第二證人的簽名

日期/時間

(如口頭的/電話/病人圖印)

Witness' Signature

Date/Time

Second Witness' Signature

Date/Time

(If Oral/Telephone/Patient Mark)

擔保人的簽名

日期

請用印刷體書寫姓名

Signature of Guarantor

Date

Please Print Name