

ADMISSION AGREEMENT

住院协议书

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.

如果您对本文件有任何疑问或对任何部分有任何不解，或需要翻译人员，请向您的医生或其他保健提供者寻求帮助。

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)

患者姓名: _____

主治医生姓名: _____

住院日期: _____ 时间: _____ (上午) (下午)

本人, _____, 兹
(患者姓名或患者授权代理人的姓名)

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.

同意指定的主治医生及其他参与治疗的医生提出之认为必需的、且由该医院及其医务人员、员工、代理人和学生来管理或提供的照顾和治疗。

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).

本人承认，在该医院中所接受的医疗照顾完全符合主治医生的指示。该医院对主治医生的医疗行为或失职不负任何责任。

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.

本人理解内科与外科的治疗不是精确无误的科学，并且在诊断和治疗过程中可能会有造成伤害甚或死亡的风险。本人承认该医院对我所作的检查与治疗的结果是无法保证的。

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.

我了解该医院中的许多医生与医务人员，包括上面提及之主治医生，可能不是该医院聘用的员工或代理人，可能是已获批准使用医院设备来照顾和治疗患者的独立承包人。而且，我本人了解除非特别要求，否则在为患者治疗期间，可能会有正在接受培训的医生、护士及其他医疗保健人员在场，以作为教育的一部分。若患者无特别声明，则治疗过程中的照片、视频或其他电子图像将可能用来教学。

RELEASE OF INFORMATION

信息发布

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:

本人特此承认该医院及本人的主治医生可以通过电子或其他方式将任何与我的护理有关的医疗信息披露给：

- any health professionals involved in my care for the purpose of facilitating the continuity of my medical care
- 为促进我的医疗服务之延续性而参与与我相关之护理的任何专业保健人士
- 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
- 任何负责为我支付在该医院中由其员工或在该医院或其附属医院中由任何个人向我提供的医疗服务之费用的个人或实体、或代理人或代理机构，以及负责付费的第三方（包括第三方付款人、自费保险人、劳工补助金管理者及政府机构等）
- 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
- 任何联邦、州或其他政府或准政府机构或其他部门依据法律要求而用作报告之目的，或用作判定加入政府资助福利计划资格之依据
- 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
- 任何参与医疗质量研究、医疗利用率审查的个人或实体或提出类似护理研究的医院、附属医院及/或其医生
- the supplier of any blood or blood products which may administered to me for the purposes of quality control and recipient monitoring
- 任何我可能使用的血液或血制品之供应商，用以进行产品质量控制和接受者监控
- any continuing care, residential, or long-term facility, or home health agency for the purpose of providing services for my care

- 任何持续性护理、住宅式或长期护理机构，或居家保健机构，用以为我提供护理服务

PATIENT RIGHTS

患者的权利

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

本人承认本人已收到有关身为该医院的患者而享有的患者权利之信息说明。

ADVANCE DIRECTIVES

预先医疗指示

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.

本人承认相关人员已向我询问是否有预先医疗指示，并已向我告知，我有做出医疗决定及根据州法律和医院尊重预先医疗指示的相关政策来拟定预先医疗指示的权利，以及决定是否拟定预先医疗指示的权利，以及不会受到歧视的权利。

Patient initials

患者姓名
首字母

VALUABLES/PATIENT RESPONSIBILITY

贵重物品/患者责任

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.

我已被告知在住院期间需将贵重物品留在家中（或将其寄存在医院内的保险箱中）。如果没有依照规定，我愿意承担任何个人财产（包括现金、信用卡、衣服、珠宝、眼镜/隐形眼镜、假牙（牙套）、助听器、文件、行李箱或其他物品）在住院期间丢失和损失的全部责任。

PAYMENT FOR MEDICAL AND RELATED CARE

医疗和相关护理服务之费用

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.

我同意承担医院和医生在我住院期间向我提供之所有服务的费用。许多向患者提供服务的医生为独立承包人，而非该医院聘用的员工或代理人。因此，我了解，我可能会收到一份他们所提供之服务的单独帐单。如果本人未能如投保人、福利计划或其他偿付人之要求而提供推荐人、其他人的意见或护理的预先证明，本人，作为患者和/或保证人，在某些情况下需个人承担所产生的全部费用。

ASSIGNMENT OF BENEFITS
权益转让

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.

就在该医院产生的医疗和相关护理之任何和全部费用问题，本人特此授权向该医院和/或在向该医院向我提供服务的独立承包人转让 Medicare、Medicaid 或任何第三方偿付人的任何类型的偿付款或付款。

NOTICE OF PRIVACY PRACTICES
隐私惯例公告

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.

本人特此承认，已收到一份该医院的隐私惯例公告之复件，其中阐释了医院使用和披露任何受保护之信息的相关规定。

Patient
initials

患者姓名
首字母

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

相关人员已就此协议书向我进行了详细说明，我确定已理解其内容及重要性。

Patient's Signature *Date/Time* *Signature/Relationship*
Date/Time (*Parent/Legal Guardian/Responsible Person*)

患者签名 日期/时间 签名/关系
日期/时间 (父母/法定监护人/责任人)

Witness' Signature *Date/Time* *Second Witness' Signature*
Date/Time (*If Oral/Telephone/Patient Mark*)

证人签名 日期/时间 第二证人签名
日期/时间 (如口述/电话/患者标记)

Signature of Guarantor *Date* *Please Print Name*

担保人签名 日期 请正楷书写姓名