CO0030

CONDITIONS OF ADMISSIONS

CONSENT TO MEDICAL, SURGICAL PROCEDURES AND BEHAVIORAL HEALTH

I consent to the procedures that may be performed during this hospitalization or while I am an outpatient. These may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, behavioral health (Mental Health and Substance Abuse), telehealth services, anesthesia, or hospital services provided to me under the general and special instructions of my health care provider. I understand that the practice of behavioral health, 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 regarding the result of examination or treatment in this hospital.

Southern Mono Healthcare District d/b/a Mammoth Hospital is a federally designated Critical Access Hospital and does not have a doctor of medicine or doctor of osteopathy, or behavioral health provider present in the hospital 24 hours per day, 7 days per week. Therefore, a doctor of medicine, of osteopathy, or behavioral health provider may not be present during all hours services are furnished to you.

NURSING CARE

This hospital provides only general duty nursing care unless, upon orders of the patient's health care provider, the patient is provided more intensive nursing care. 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 his/her legal representative. The 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 said patient is not provided with such additional care. In the event of transfer of care, the undersigned consents to obtaining records from the receiving facility relevant to the transfer from Mammoth Hospital.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

All physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist and others, are not employees, representatives or agents of the hospital. They have been granted the privilege of using the hospital for the care and treatment of their patients, but they are not employees, representatives or agents of the hospital. They are independent practitioners. Mammoth Hospital participates in the training of medical students who may be observing your medical care. If you are opposed to any observers please notify your health care provider.

I understand that I am under the care and supervision of my health care provider. The hospital and its nursing staff are responsible for carrying out my health care provider's instructions. My health care provider is responsible for obtaining my informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, behavioral health services, or hospital services provided to me under my health care provider's general and special instructions.

MATERNITY PATIENTS

If I deliver an infant(s) while a patient of this hospital, I agree that these same Conditions of Admission apply to the infant(s).

PHOTOGRAPHY FOR SCIENTIFIC, EDUCATIONAL AND RESEARCH PURPOSES

I consent to the taking of pictures of my medical or surgical condition or treatment, and the use of the pictures for scientific, educational or research purposes.

PERSONAL BELONGINGS

As a patient, I am 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, eyeglasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices, or other articles that are not placed in the safe. Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500) unless I receive a written receipt for a greater amount from the hospital.

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FINANCIAL AGREEMENT
I agree to promptly pay all hospital/clinic bills in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. I understand that I may review the hospital's charge description master before (or after) I receive services from the hospital. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

ASSIGNMENT OF ALL RIGHTS AND BENEFITS
I irrevocably assign and transfer 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 my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this hospital to perfect, confirm, or validate this assignment.

GRIEVANCE PROCESS
You have the right to file a grievance. Please ask a hospital representative for more information or call the Quality Department at (760)924-4020.

HEALTH PLAN CONTRACTS
This hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the financial office. All health care providers, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if the hospital or the health care providers providing services to me contract with my health plan.

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
To the extent permitted by law, your protected health information may be used and disclosed as necessary for this hospital to carry out treatment, payment or healthcare operations. It is the policy of this hospital to take every necessary measure to safeguard the privacy of your protected health information. Protected health information includes information that has been created or received by a health care provider that relates to your past, present or future mental or physical condition and that is personally or individually identifiable as belonging to you. For our policies regarding the protection of your health care information, please refer to our Notice of Privacy Practices. It is your right to review our policies prior to providing your consent for the disclosure of your protected health information.

In addition, this hospital is a participant in Commonwell, a secure health information exchange that facilitates the electronic transfer of health information amongst those providers involved in your care that are participants in the health information exchange. Through Commonwell, this hospital may disclose your protected health information to other health care provider participants only for medical treatment purposes. In cases where your specific consent or authorization is required to disclose certain health information, this hospital will not disclose that health information to other health care providers participating in the exchange without first obtaining your specific consent therefor. All participating health care providers must account for all disclosures of your protected health information that were made for treatment purposes, and you have the right to access your medical records or obtain information about who has requested or received them.

While your consent to the disclosure of your protected health information via Commonwell will help to create a continuum of care related to your medical treatment, you have the right to opt out of sharing your protected health information through Commonwell. If you do not opt out of sharing your protected health information via Commonwell, your consent to such sharing shall be assumed. If you would like to opt out, you may exercise your right to do so by requesting and signing the Commonwell opt-out form. The effect of opting out is that each participating health care provider will need to request that a copy of your record be transferred by other means.

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I certify that I have read the foregoing and received a copy thereof. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf.

Date/Time:_____

Signature:_____
(patient/legal representative)

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

Print name:_____
(legal representative)

*Signature:*_____
(witness)

*Print name:*_____
(witness)