SSMHealth

Patient Name:
Medical Record:
Account #:
Date of Service:
Attending Physician:

CONDITIONS OF TREATMENT FOR HOSPITALS[1]

Consent to Medical Care: I request and consent to the medical care and diagnostic treatment procedures as determined necessary by my healthcare provider, and as agreed by me, my legal guardian or my personal representative. I acknowledge the care I receive while in this facility is under the direction of my physician(s). I understand that I will continue to be informed of my care options as my course of treatment progresses.

I understand that in the unlikely event that a healthcare provider is exposed to my blood or bodily fluids through an accidental needle stick or otherwise, for their protection my blood may be tested for the Hepatitis B Virus, (HBV), Hepatitis C Virus (HCV), and Human Immunodeficiency Virus (HIV), and I hereby consent to such testing. I understand that the test is performed by withdrawing blood and using a substance to test the blood. I understand that a test result which confirms the presence of any of these diseases must be reported to the State Department of Health as a reportable communicable disease.

Independent Medical and Allied Health Care Providers: I have been informed and understand: a) that physician(s) providing services to me in this facility, such as my personal physician(s), radiologists, pathologists, anesthesiologists, emergency department physicians, consulting physicians, surgeons and other allied health care providers such as psychologists and nurse anesthetists, are independent contractors and are not employees or agents of this facility unless otherwise specifically identified, (b) that all these persons exercise their own independent professional judgment in my care and treatment, (c) this facility cannot and does not control the professional actions and judgment of such independent providers, and, (d) this facility is not responsible for the acts or omissions of these health care providers.

Teaching Programs: I understand that this hospital or clinic may participate in teaching programs to train future doctors, nurses, and allied health professionals and that, from time to time, residents, interns, medical students, nursing students and various allied health professional students may participate in my care. I understand that I may limit my participation in these teaching programs at any time by informing my doctor, nurse, or other healthcare professional that I do not want residents, interns, or students to participate in my care.

Release of Information: I have received on this visit/admission or a previous one, the Notice of Privacy Practices that explains how the facility may use my information. I agree that this facility may use and release information about me as set forth in the Notice of Privacy Practices. The Notice of Privacy Practices is also available on the SSM Health website. As explained in the Notice of Privacy Practices, the facility will only obtain my written authorization to release information about me if use or release of my information without authorization is not permitted either by law or the Notice of Privacy Practices.

Medicare/Champus/Tricare Rights: If applicable, I understand that I should receive the Medicare/Tricare Letter explaining my rights. I understand this includes my right to request a review by the Payor.

Patient Rights: I acknowledge that I have received or otherwise been informed of Patient Rights information explaining my rights as a patient in this facility.

Personal Property: I have been informed and understand this facility will not be liable for any loss of my personal property unless it is inventoried and placed in a secured area maintained by this facility.

Payment for Medical and Related Care: I agree to pay the facility's set and established charges incurred for the care I receive as ordered by my physician(s) at this facility, including separate charges by independent contractors (such as emergency department physicians, radiologists, psychologists and anesthesiologists). If I do not have valid insurance or my insurance does not provide coverage for part or all of my care as part of my benefits, I guarantee full payment of all charges unless restricted by Medicare or Medicaid. These charges include, but are not limited to, services to screen, and, if necessary, stabilize an emergency medical condition. I understand that I may receive more than one bill for the care I receive at this facility because my physicians or other independent medical and allied health care providers may bill for their professional fees separately from each other and separately from the facility's set and established charges, facility fee, and/or technical fee. The facility fee or technical fee is charged for such things as nursing, technician, and housekeeping support, medical records administration, and the use of equipment, technology and

[1] Includes Provider-Based Locations

routine supplies. I also understand that depending on my insurance coverage and deductible amounts, the facility fee could increase my out-of-pocket costs. Additionally, I understand that the physicians and other independent medical and health care providers may be contracted with insurance companies that differ from the facility. Thus, my financial responsibility may be greater for services received, and if I have any questions about my benefits coverage, I will contact my insurance company directly.

Assignment of Benefits: I hereby assign all of my rights and benefits under my existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the facility, affiliated physicians, and/or other independent contractors and authorize direct payment to these parties for such services and treatment. I understand that most health insurance payers, including Medicare and Medicaid, are secondary payers to any existing liability policies, no-fault insurance, workers compensation or any other sources of payment that may or will cover expenses incurred for services and treatment.

I hereby appoint the facility, affiliated physicians, other independent contractors, and any agent acting on their behalf as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for the collection against any responsible payer or third-party liability carrier of all benefits due me for the payment of charges associated with my treatment.

Consent to Electronic Surveillance: The facility reserves the right to implement policies for purposes of promoting the safety and security of the facility, its patients, visitors, employees and medical/professional staff. I understand and agree that the facility may engage in electronic surveillance in public areas, and that I may be photographed, videotaped, audiotaped or have digital or other images (audio, video, or both) (collectively referred to as "Images and/or Other Recordings") of me recorded while in public areas of the facility. I further understand that these Images and/or Other Recordings will be accessed and stored in a secure manner that will protect my privacy to the greatest extent possible and that they will be maintained and stored in accordance with facility policies.

Photography, Video, Audio Recordings, and Other Imaging: I understand photographs and recordings may be taken of me during my care for purposes of identification, diagnosis and treatment. I further understand clinical recordings or photographs that do not include personally identifiable information may be used internally for medical education and teaching purposes. Unless required by law, the use or release of photographs and recordings for any other purpose requires my express written consent.

Communication Concerning Services and Debt Collection: I authorize this facility to communicate with me for any reason related to the provision of services, including collection of amounts owed for services, using text messaging services, an automatic telephone dialing system or prerecorded voice at the telephone number(s) I provided, including a telephone number assigned by a cellular telephone service or any service for which I am charged for the call. In addition, I consent to and agree that any calls between this facility and I may be monitored and/or recorded for any purpose. In the event that debt collection becomes necessary, I also authorize this facility, including any collection agency or debt collector hired by this facility, to check my credit and employment history, obtain a copy of my consumer report and obtain personal information from any consumer reporting agency.

Acknowledgement and Certification:

By signing this form, I certify that I am the patient or the patient's legal representative, I have read this Conditions of Treatment form, I was given the opportunity to ask questions, and I understand and accept all terms herein.

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

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

Print	**Date/Time**	**Signature of Guarantor/Beneficiary (if present)**

Revision Date: October 31, 2019