

- 7. **ACKNOWLEDGEMENT OF CHARITY CARE/DISCOUNT PAYMENT POLICIES:** I understand that the hospital has a charity care program and discount policy available. If I am interested in more information or believe that I may qualify, I am to contact the hospital's financial counselors at (310) 829-8007.
- 8. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN/SURGEON:** All physicians and surgeons, including the radiologist, pathologist, anesthesiologist and other physician specialties, as well as non-employed physician assistants and nurse practitioners, furnishing services to the patient, are independent contractors and are not employees or agents of the hospital. The physicians and surgeons will bill me separately for their services. **Patient initials:** _____
I understand that I am under the care and supervision of my attending physician or surgeon, and it is the responsibility of the hospital and its nursing staff to carry out the instructions of my physician or surgeon. It is the responsibility of my physician or surgeon to obtain my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to me under the general and special instructions of the physician or surgeon. Any questions concerning the nature or results of any examination or treatment should be directed to my attending physician or surgeon.
- 9. **FINANCIAL AGREEMENT:** I agree, whether signing as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to promptly pay the account of the hospital in accordance with the regular rates and terms of the hospital. I understand that all physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill me separately for their services. Should any account be referred to an attorney or collection agency for collection, I shall pay all actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the highest rate allowed by law. **Patient initials:** _____
- 10. **HEALTH PLAN OBLIGATION:** The hospital maintains a list of the health plans with which it has contracted. A list of such plans is available upon request from the financial office. The hospital has no contract, express or implied, with any plan that does not appear on the list. I agree, whether signing as agent or as patient, that I am individually obligated to pay the full charge for all services rendered to the patient by the hospital, if I or the patient belongs to a plan which does not appear on the above-mentioned list. All physicians and surgeons, including the radiologist, pathologist, emergency physician, anesthesiologist, and others, will bill separately for their services. It is my responsibility to determine if physicians providing services to the patient contract with the patient's health plan, if any.
- 11. **I HAVE RECEIVED:**

<input type="checkbox"/> Patient Information Guide	I have an Advance Directive <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Important Message from Medicare	Copy presented today <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Smoking Cessation Information	
<input type="checkbox"/> Other	

I certify that I have read the foregoing, received a copy thereof, and am the patient, the patient's legal representative, or am duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

Date: _____ Time: _____ am/pm Signature: _____
(Patient/Parent/Guardian/Conservator/Agent)

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

Financial Responsibility Agreement by Person other than the Patient or the Patient's Legal Representative:

I agree to accept all financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Care Service Plan Obligation provisions enumerated above.

Date: _____ Time: _____ am/pm Signature: _____
(financially responsible party)

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

A COPY OF THIS DOCUMENT IS TO BE DELIVERED TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT.

ADDRESSOGRAPH



SANTA MONICA, CA 90404

CONDITIONS OF ADMISSION TO SAINT JOHN'S HEALTH CENTER

CONDITIONS OF ADMISSION TO SAINT JOHN'S HEALTH CENTER

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES:**

I consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, photographs for purposes related to diagnosis or treatment or for the hospital's operations, including peer review and training and educational programs conducted by the hospital, anesthesia, or hospital services rendered to me under the general and special instructions of the patient's physician or surgeon. 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 regarding the result of examination or treatment performed at this hospital.

2. **NURSING CARE:** The hospital provides only general duty nursing care unless, upon orders of my attending physician or surgeon, I will be provided with more intensive nursing care. If my condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by me or my 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 I am not provided with such additional care.

3. **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).

4. **RELEASE OF INFORMATION:** Upon an authorized inquiry and to the extent allowed by law, the hospital may make available to the public certain basic information about me, including name, patient's room number (if admitted) and a general statement of condition (i.e. critical, stable, fair, etc.). If I or my representative does not want such information to be released, either must make a written request for said information to be withheld. I or my representative must request and obtain a separate form from the hospital for this purpose. The hospital shall not release information, other than such basic information without my consent and written authorization to release such information, except in those circumstances where the hospital is permitted or required by law to release information without my consent or authorization. I agree to the release of such information for research or teaching purposes as permitted by law. I agree to the release of any diagnostic imaging studies to be viewed by Santa Monica Wilshire Imaging, LLC and Tower Imaging Medical Group, LLC personnel and physicians as minimally necessary for the continuity of care. I agree that, to the extent necessary to determine liability for payment and to obtain reimbursement, and only as permitted or required by law, the hospital may disclose portions of my record, including my financial and medical information, to any person or entity which is or may be liable for all or any portion of the hospital's charges, including but not limited to government agencies (e.g., Medicare), insurance companies, health care service plans, or workers' compensation carriers.

[Various laws require the hospital to report certain cases of infectious disease, cancer, and other specific medical diagnosis and observations to governmental health agencies without the need for obtaining patient consent. Please refer to the Hospital's Notice of Privacy Practices for further information.]

5. **PERSONAL VALUABLES:** As a patient, I am encouraged to leave personal items at home. It is understood and agreed that the hospital maintains a fireproof safe for the safekeeping of money and valuables, and that the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, or other articles of unusual value and small size, unless placed therein. In addition, the hospital shall not be liable for the loss of or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for the loss of or damage to any personal property which is deposited with the hospital for safekeeping is limited by statute to five hundred dollars (\$500.00).

6. **ASSIGNMENT OF INSURANCE BENEFITS:** I assign and authorize direct payment to the hospital of any insurance or other applicable (e.g., Medicare) benefits otherwise payable to or on behalf of myself or the patient for this hospitalization or for these outpatient services, including emergency services if rendered. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is further understood that I am financially responsible for charges not collected by this assignment unless otherwise prohibited by applicable written contract or law.

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Date: _____ Time: _____ am/pm Signature: _____
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If signed by other than patient, indicate relationship: _____ Witness: _____

Financial Responsibility Agreement by Person other than the Patient or the Patient's Legal Representative:

I agree to accept all financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Care Service Plan Obligation provisions enumerated above.

Date: _____ Time: _____ am/pm Signature: _____
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