CONDITIONS OF ADMISSION

1. **NURSING CARE:** This hospital provides only general nursing care unless the patient's physician orders 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.

2. **MEDICAL AND SURGICAL CONSENT:** The patient is under the care and supervision of his/her attending physician, and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. The undersigned hereby consents to X-ray examination, laboratory procedures, anesthesia, emergency treatment, medical or surgical treatment, or hospital services rendered to the patient under the general and special instructions of the physician. **OBSTETRICAL ADMISSIONS:** These Conditions of Admission apply to the baby as well.

3. **RELEASE OF INFORMATION:** To the extent necessary to determine liability for payment and to obtain reimbursement, the hospital or attending physicians may disclose portions of the patient's record, including his/her medical records, to any person or corporation, which is or may be liable, for all or any plans, or worker's compensation carrier (Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.) The hospital may release the patient's name and address to its Foundation for hospital fund raising activities.

4. **PERSONAL VALUABLES:** It is understood and agreed that the hospital maintains a safe to protect the patient's personal property, money and valuables. The hospital shall not be liable for any loss or damage to the patient's personal property, money or valuables unless those items have been deposited within the hospital safe. The maximum total (combining all items/cash placed in the safe) monetary liability assumed by the Medical Center for items and cash placed in a safe will not exceed $500.

5. I have received information on the preparation of an Advance Directive.

6. **SAFE ENVIRONMENT FOR PATIENT CARE:** Weapons or other dangerous objects, illegal drugs, and drugs not prescribed by the patient's physician are not permitted in the patient's room. The Medical Center's obligation to provide a safe environment for patient care must override the patient's right to privacy. The Medical Center reserves the right to search the patient and room and to confiscate such objects upon reasonable probable cause.

7. **FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital and/or as set forth by the terms of managed care contracts entered into by Providence Health System and/or applicable Worker's Compensation regulations. Should the account be referred to an attorney/agency for collection, the undersigns shall pay actual attorney's fees and collection expense. All delinquent accounts shall bear interest at the legal rate.

YOU ARE RESPONSIBLE TO PAY, OR MAKE APPROPRIATE ARRANGEMENTS FOR PAYMENT, FOR ALL PHYSICIAN AND OTHER INDEPENDENT PROVIDERS THAT PROVIDE MEDICAL AND OTHER CLINICAL SERVICES TO YOU DURING YOUR HOSPITAL STAY.

PATIENTS ENROLLED IN MANAGED CARE HEALTH PLANS: I understand that I am responsible for guaranteeing my eligibility and obtaining approval for services from my HMO/PPO plan, or I must plan for payment of services rendered at this time. I agree to be financially responsible for any and all charges for this visit if not covered by my Health Plan.

8. **ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned authorizes, whether he/she signs as agent or patient, direct payment to the hospital or physicians, medical groups and practitioners or any insurance benefits otherwise payable to the undersigned for his hospitalization at a rate not to exceed the hospital's regular charges. 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 understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. The terms and conditions above also apply to emergency room treatment which does not require hospital admission.

9. **MEDICARE INSURANCE BENEFITS AND EXCLUSIONS:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. Some services may not be covered by Medicare, such as the following: 1) Workers's Compensation, 2) Dental, 3) Cosmetic Surgery, 4) Custodial Care, 5) Personal Comfort Items, and any service determined to be unnecessary or unreasonable by Medicare.

The undersigned understands that the Department of Health and Human Services Health Care and Financing Administration requires the patient's signature to release Medicare/Medi-Cal eligibility information. The undersigned authorized the Social Security Administration to release the following information to Providence Health System

10. **HEALTH CARE SERVICES PLANS:** This hospital maintains a list of health care service plans with which is 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. The undersigned agrees that he/she is individually obligated to pay the full cost of services rendered to him/her by the hospital if he/she belongs to a plan which does not appear on the above mentioned list.

11. **CONSENT TO OBSERVE AND PHOTOGRAPH:** Observers will be allowed according to the Medical Center policy as will the taking of pictures of medical or surgical procedures and the use of same for internal staff education or process improvement purposes. Observation and photography or medical or surgical procedures may be done with the approval of the hospital and in accordance with hospital policy.

12. **RESTRAINTS:** Whenever possible, every attempt is made by the Medical Center to avoid the use of estraints. Restraints are used only if other methods have been tried and have not been successful. A restraint may be used to maintain the position of the patient in bed or in a chair. A restraint may be used to prevent the patient from injuring himself/herself or others. A restraint may be used to prevent the patient from pulling on or removing a tube or IV line. If other methods for protecting, the patient/others or treatment tubes/lines have not been effective, a restraint may be needed. In order to provide compassionate care for the patient, the following steps will be followed: a) a physician's order is obtained; b) The family or responsible individual is notified of the need and reason for a restraint; c) The least amount of restraint is used; d) The patient's needs including safety, hygiene, elimination, positioning, and nutrition will be assessed frequently and appropriate nursing care provided; e) The restraint will be released at regular intervals, circulation and movement checked, and range of motion provided; f) The need for restraint will be re-assessed continuously and will be removed as soon as possible.

13. **PHYSICIAN'S ARE INDEPENDENT CONTRACTORS:** The undersigned recognizes that all physicians, physician assistants, and surgeons furnishing service to the patient, including the radiologist, pathologist, anesthesiologist, emergency room physician, physician assistants, and the like, are independent contractors and are not employees or agents of the hospital.

Initials

14. **NOPP:** I have received a Notice of Privacy Practice (NOPP) which explains how my medical information may be used.

Initials

Patient refuses, or is unable, to acknowledge receipt of NOPP.

Employee Signature:_____ Date:_____

15. **NOTICE OF UNINSURED PATIENT RIGHTS WITH RESPECT TO COLLECTION OF DEBTS FOR HOSPITAL SERVICES AND ASSEMBLY BILL 774:** I have been notified of uninsured financial guidelines, including information regarding qualification for payment discounts, MediCal coverage, California Healthy Family coverage, as well as other government programs.

Initials

PATIENT RIGHTS: I have received a copy of the Patient Rights Form.

Initials

FEES AND BILLING: I have received a copy of "Patient's Guide to Fees and Billing" brochure:

Initials

SMOKING CESSATION: Written smoking cessation information provided to the patient/family upon admission

CALIFORNIA PROPOSITION 65 WARNING

Some medical devices and drugs used in the Medical Center may fall under the Proposition 65 list of chemicals known to the State of California to cause cancer, birth defects, or other reproductive harm.

TRANSLATION (if necessary). I have accurately and completely read the foregoing document to the signatory identified below in the patient's/patient representative's primary language. He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence.		PRIMARY LANGUAGE IF NOT ENGLISH:
		SIGNATURE OF TRANSLATOR
		REASON PATIENT DID NOT SIGN
SIGNATURE OF PATIENT/PATIENT'S REPRESENTATIVE X	DATE / TIME	
	Witness	TITLE / DEPARTMENT

RELATIONSHIP IF OTHER THAN PATIENT ☐ PARENT ☐ CHILD ☐ SIBLING ☐ GUARDIAN ☐ REGISTERED DOMESTIC PARTNER ☐ OTHER (Specify)

Providence | Health System

Southern California Region

Providence Saint Joseph Medical Center
501 S. Buena Vista Street
Burbank, CA 91505
(818) 843-5111

Providence Holy Cross Medical Center
15031 Rinaldi Street
Mission Hills, CA 91346
(818) 365-8051

Little Company of Mary - Torrance
4101 Torrance Blvd
Torrance, CA 90503
(310) 543-5918

Little Company of Mary - San Pedro
1300 West 7th Street
San Pedro, CA 90732
(310) 832-3311