SSM HEALTH · CARE

ST MARYS HOSPITAL MEDICAL CENT
707 SOUTH MILLS STREET
MADISON, WI 53715

Patient Name: TEST,PATIENT
Medical Record #: 000123456
Account #: 0123456789 Type: O/P
Date of Service: 01/18/05 09:06
Attending Physician: TEST,DOCTOR

CONDITIONS OF ADMISSION AGREEMENT

Consent to Admission: I request and consent to admission.

Consent to Medical and Related Health Care: I request and consent to the medical care, diagnostic and treatment procedures as determined necessary by my physician(s) or his/her assistants. I acknowledge the care I receive while in this facility is under the direction of my physician(s). This facility is not responsible for the acts or omissions of my physician(s).

Medical and Allied Health Care Providers: I have been informed and understand that the Physician(s) providing services to me in this facility, such as my personal Physician(s), Radiologists, Pathologists, Anesthesiologists, Consulting Physicians, Surgeons and other Allied Health Care Providers such as Dentists and Psychologists are independent contractors and are not employees or agents of this facility unless otherwise specifically identified.

Teaching Programs: I understand this facility may, from time to time, enter into agreements with academic medical, nursing and allied health programs. Because of these agreements, residents, interns, medical students, nursing students and various allied health profession students, may participate in my care. I agree to participate in these programs, but have the right to limit my participation at any time.

Release of Information: I understand this facility will make every effort to treat my medical information as confidential; however, I realize information must be shared with providers and/or individuals involved in my care or in the payment of my care. I understand this will include information found in my medical record. I agree to the release of information in my medical record, and to the actual medical record documents to the extent necessary for the following purposes:

a.) I have received the Notice of Privacy Practices on this visit/admission or a previous one. I understand I can request another copy at any time.

b.) to any medical and/or health care providers responsible for my care while in this facility and if transferred to another facility for care, to that facility and its care providers.

c.) to those responsible for collecting and those responsible for the payment of my care. This may include a person, government agency, insurance company, health plan or employer sponsored group plan. This is for the purpose of verifying insurance benefits for precertification, extended stay review and/or the payment of the cost of my care.

d.) to utilize for internal medical care studies and quality improvement activities.

e.) to comply with the Federal Safe Medical Device Act of 1990 and other required state and federal reporting.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME ('AIDS').

If I do not indicate whether some other party will be paying my bill, I hereby authorize this facility to release any and all of my medical records to an agent of this facility for the purpose of determining whether a third party payor will be paying my bill or, if not, whether I am eligible for any governmental assistance.

Medicare/Champus/Tricare Rights: If applicable, I acknowledge receipt of the Medicare/Champus/Tricare Letter explaining my rights as a patient of this facility. I understand this includes my right to request a review.

Patient Rights: As an Inpatient, I acknowledge receipt of the Patient Rights information explaining my rights as a patient in this facility. As an Outpatient, I acknowledge that I will receive the Patient Rights upon request.

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.

(Continued on reverse side)

Payment for Medical and Related Care: I agree to pay the charges incurred for the care I receive as ordered by my physicians(s) at this facility, including charges by independent contractors (such as Radiologists, Psychologists and Anesthesiologists.) 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.

Assignment of Benefits: 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.

Acknowledgement of Understanding Receipt: ***I certify that I have read and understand the preceding agreement. I have had any unclear items explained to me and understand its contents and accept its terms.***
I understand that new account numbers may be issued for follow up services related to this admission/treatment and that would not change this agreement or be considered a discharge by Medicare. I understand I may withdraw my agreement to the preceding at any time by written notification to this facility.

_______________________________ OR _______________________________

Patient's Signature Date

TEST,PATIENT 0123456789 000123456

Signature/Relationship Date
(Parent/Legal Guardian/Responsible Person)

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Witness Signature Date

____

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

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Signature of Guarantor Date Please Print Name