1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES**
The undersigned consents to the procedures that may be performed during this hospitalization or on an outpatient basis. These may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services rendered the patient under the general and special instructions of the patient's physician or surgeon. The undersigned understands 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. There are certain types of procedures, such as direct abortion, which are not authorized in this hospital. The undersigned agrees and acknowledges that no guarantees have been made regarding the result of examination or treatment in this hospital.

2. **NURSING CARE**
This hospital provides only general nursing care and care ordered by the patient's physician(s). If the patient wants a private duty nurse, the undersigned agrees to make such arrangements on his/her own or through his/her legal representative. The hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

3. **PARTICIPATION IN MEDICAL EDUCATION / TEACHING PROGRAMS**
It is understood that the hospital is a teaching institution. The patient may be part of a Medical Education Program, and may receive treatment by residents, with approval of patient's attending physician, and those clinical students acting under appropriate supervision as required by such Medical Education and clinical training programs.

4. **CONSENT TO PHOTOGRAPH**
I consent to the taking of photographs, videotapes, digital or other images of my medical or surgical condition or treatment, and the use of the images for purposes of my diagnosis, treatment, monitoring or for the hospital's operations, including peer review and education or training programs conducted by the hospital.

5. **MATERNITY PATIENTS**
If the patient delivers an infant(s) while a patient of this hospital, the undersigned agrees that these same Conditions of Admission apply to the infant(s).

6. **PERSONAL BELONGINGS/VALUABLES**
The patient is 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, or other articles that are not placed in the safe.

☐ Initial Here

7. **PATIENT SAFETY**

Covenant Medical Center encourages anyone who has concerns about safety or quality of care to bring those concerns first to the staff providing your care, the immediate person in charge or the Department Manager to ensure that your concerns are addressed and resolved. You may also contact Patient Representative at (806) 725-4352.

Anyone wishing to contact The Joint Commission regarding quality concerns may do so online at www.jointcommission.org or by calling toll free (800) 994-6610.

8. **CONSENT TO RELEASE AND USE OF RECORDS**

The undersigned hereby consents to and authorizes the release of medical records to insurance carriers, third-party payers or their representatives, and/or review organizations as deemed necessary to determine benefits entitlement and to process payment claims for health services provided.

The undersigned authorizes the release of medical record information to the physician(s) or agency responsible for his/her follow-up care, and/or to the healthcare facility to which he/she is transferred from Covenant Medical Center. The undersigned authorizes Covenant Medical Center to access, release, and share accessible electronic medical information with other medical providers who utilize an electronic medical record system compatible with Covenant Medical Center.

The undersigned authorizes release of his/her medical record information as required by law.

The undersigned understands his/her records may be released to state, federal, or other surveyors for accreditation and/or regulatory licensing purposes. The undersigned authorizes Covenant Medical Center to provide information to and receive information from insurance carriers, third-party payers, federal or state or local governing or administrative agencies, or their representatives, for the purpose of allowing Covenant Medical Center to be paid for his/her treatment.

9. **LAB TEST RESULTS AVAILABILITY THROUGH THE ONLINE PATIENT PORTAL**

"Yes, I hereby request and agree that my laboratory test results may be provided to the online patient portal, so that I may access them electronically as part of my clinical health record. I understand that the laboratory test results made available through the online patient portal will not include test results for HIV, hepatitis, drug abuse, or a malignancy."

Patient Signature

"No, I do not want my laboratory test results made available to me electronically through the online patient portal."

Patient Signature

10. **PHYSICIANS ARE INDEPENDENT CONTRACTORS**

All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, intensivist, hospitalist, emergency department physicians, other hospital–based physicians and some nurse practitioners, physician assistants, are independent contractors and are **not** employees or agents of the hospital. The hospital–based physicians' fees are billed separately and independently of hospital charges, which means the patient will receive multiple bills. While the patient is under the care and supervision of his/her attending physician, the hospital and its nursing staff will carry out the instructions of such physician or surgeon, and obtain the patients consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and specific instructions of the physician.

It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered the patient under the general and specific instructions of the physician.

Patient Signature

11. TELEPHONE CONSUMER PROTECTION AND CAN-SPAM ACTS

By providing the Hospital or its service providers with a telephone number for a cellular or other wireless device and/or an e-mail, the patient/patient representative agrees that the Hospital or its service providers may use the provided telephone number and/or e-mail to service patient account(s) (including contacting the patient/patient representative about obtaining potential financial assistance for the patient's account(s)), to send the patient/patient representative appointment and follow-up health care reminders by text and/or e-mail, to send the patient/patient representative information, to schedule patient appointments, and to collect any amounts the patient/patient representative may owe to the Hospital. The patient/patient representative understands and agrees that the Hospital and its agents, representatives, or other service providers as well their respective agents and contractors, including any billing or account management companies and/or debt collectors may contact the patient/patient representative at the provided telephone number(s) which could result in charges to the patient/patient representative. By indicating approval below, the patient/patient representative expressly consents that methods of contact may include using pre-recorded and artificial voice messages, text, email, (if an email address has been provided) and/or the use of an automatic dialing device, as applicable. By declining consent below, any such calls or communications will be made by a "live" person. This consent applies to all services and billing associated with patient's account number(s) and is not a condition of purchasing property, goods, or services. The patient/patient representative is not required to sign this consent as a condition of admission to the Hospital.

	Patient/Patient Representative Initials – Approve receipt of pre-recorded, artificial, and automatic dialed telephone calls, text messages and emails.
	Patient/Patient Representative Initials – Decline receipt of pre-recorded, artificial, and automatic dialed telephone calls, text messages and emails.

12. AUDIO/VIDEO RECORDING AND DISTRIBUTION BY PATIENTS

I understand that I may not film, record or distribute any images or sounds of my/our conversations or interactions with any St. Joseph Health employee or physician without the consent of all parties to the conversation or interaction. I also understand that I am prohibited from filming, recording or distributing any images or sounds of another patient's confidential interactions with St. Joseph Health employees or physicians, without the consent of all parties whose images or voices are captured in the recording. St. Joseph Health reserves the right to request that I stop such filming, recording, or distribution at any time if I have not obtained all necessary consents.

13. ACKNOWLEDGEMENTS

This is to acknowledge that the undersigned has been offered and/or given the Notice of Privacy Practice, Important Patient Information, Patient's Rights and Responsibilities, and Patient Safety.

Signature

CONDITIONS OF ADMISSION

14. AGREEMENT

The undersigned certifies that he/she has read the Conditions of Admission, received a copy, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient/Patient Representative	Relationship to Patient	Date/Time(For Manual Signature Only)
Witness	Reason Patient Unable to Sign	Date/Time(For Manual Signature Only)

15. ASSIGNMENT OF INSURANCE BENEFITS

This clause authorizes direct payment by insurance companies, health care service plans, and state disability or worker's compensation carriers to the hospital whenever applicable. The undersigned understands that Medicare and Medicaid are payers of last resort and authorizes not to bill those payer sources if a third party is liable to pay for his/her treatment, but rather assert a lien against any settlement the undersigned might receive from the liable party. The undersigned hereby authorizes a party against which a lien is asserted to pay directly any amounts owing under the lien. The undersigned understands that information provided to can be used to pursue medical or hospital liens for recovery of hospital and/or physician charges, and waives any requirement a lien release be recorded or filed. I hereby assign and authorize direct payment to my treating physicians as well as the hospital based physicians who have rendered professional services to me, which may include, but not be limited to, anesthesiologist, pathologist, radiologist, and hospitalist. I understand and agree that I remain financially responsible for any charges or fees which have not been paid by this assignment.

16. HEALTH PLAN OBLIGATION

This hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from _____. 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 charges of all services rendered to the patient by the hospital if he/she belongs to a plan that does not appear on the above mentioned list.

17. FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as representative, agent or as patient to promptly pay all hospital bills in accordance with the regular rates and terms of the hospital, including its charity care and discount payment policies, if applicable. Should any account be referred to an attorney or collection agency for collection, the undersigned will pay actual attorneys' fees and collection expenses even if the patient entered the emergency department involuntarily. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

FINANCIAL RESPONSIBILITY APPROVAL BY PERSON OTHER THAN PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

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

Financially Responsible Party	Relationship to Patient	Date/Time (For Manual Signature Only)
Witness	Date/Time (For Manual Signature Only)	

CONDITIONS OF ADMISSION