CONDITIONS OF ADMISSION

MEDICAL CONSENT: The undersigned consents to the procedures that may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, which may include but are not limited to 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. I understand I may be photographed or videotaped to document my medical treatment or condition or for quality review or safety purposes.

_____ _____ _____
Signature of Patient or Patient's Representative Date Time

PHYSICIANS ARE INDEPENDENT MEDICAL PRACTITIONERS: I understand that most of the physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent medical practitioners and are not employees or agents of the hospital. Some of these physicians will bill separately for their services. 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. 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 to the patient under the general and special instructions of the physician.

RESPONSIBILITY FOR ALL PERSONAL PROPERTY: I understand the hospital maintains a fireproof safe for safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, or other articles of unusual value and small size, unless placed therein, and shall not be liable for the loss or damage to any other personal property, unless deposited with the hospital for safekeeping. I also understand that the hospital is not responsible for loss or damage to glasses, dentures, hearing aids, contact lenses, or other articles. I understand the hospital cannot assume responsibility for the safety of electrical equipment brought by patients. Therefore, no electrical equipment or appliances other than those maintained by the hospital may be used. I understand that any personal property not claimed within 30 days after I am discharged will be disposed of according to the hospital policy.

FINANCIAL AGREEMENT: I agree to pay the hospital according to the regular rates and terms of the hospital for services to be rendered to me. **I understand I am financially responsible for charges not covered by my insurance or other agency. I understand I am responsible for any deductible and coinsurance.** If my insurance requires referral from my Primary Care Physician and the hospital has not received authorization from my Primary Care Provider, I will be financially responsible for any and all charges not covered by insurance.

Financial Counseling Available to determine the ability to pay and/or eligibility for possible charity discount. A credit report may be obtained to verify financial information. If this account is placed in the hands of any attorney for collection, I will pay reasonable attorney's fees and collection costs, whether or not a suit is filed. All accounts are payable in full at time of billing unless there is valid insurance coverage. If insurance denies payment, the balance may become my responsibility. If my account becomes past due, defined as 180 days past date of service, I understand I may be required to pay interest on the unpaid balance.

Assignment of Insurance Benefits: I authorize payment directly to the hospital of all insurance including Medicare or Medicaid or health plan benefits otherwise payable to me, to the extent of the patient's bill. I authorize payment directly to physicians and laboratories for related charges. It is understood by the undersigned that he/she is financially responsible for all charges not paid pursuant to this agreement.

Medicare Beneficiaries: I have received a copy of "An Important Message from Medicare". **Patient Initials _____**

OREGON HEALTH PLAN: I give my consent to release my name and admitting information to the Oregon Health Plan (OHP). I understand I may apply for benefits through OHP. The coverage may be retroactive for this admission date. I understand I may be contacted by Outreach Services related to my hospital charges. Yes No **Patient Initials _____**

I certify that I have read this financial agreement. I am the patient, or I am authorized as the patient's agent or representative to execute the agreement and accept its terms on behalf of the patient. I assume individually all financial responsibility by noting my signature below.

SIGNATURE OF PATIENT or AUTHORIZED REPRESENTATIVE:

Print Name_____

_____ _____ _____
Signature of Patient or Patient's Representative Date Time

Representative's authority to act on patient's behalf: ☐ DPOA for Healthcare Decisions
☐ Parent of Minor ☐ Guardian ☐ Surrogate ☐ Other_____

_____ _____ _____
Signature of Witness Date Time

PATIENT RIGHTS and RESPONSIBILITIES: I acknowledge receipt of my Rights and Responsibilities as a patient. **Patient Initials _____**

NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of this facility's Notice of Privacy Practices. **Patient Initials _____**

PATIENT LABEL

421904 (1/10)

West Valley Hospital
A part of Salem Health

CONDITIONS OF ADMISSION

WHITE – ORIGINAL YELLOW – PATIENT