ARKANSAS
SURGICAL HOSPITAL
PHYSICIAN OWNED

CONDITIONS OF ADMISSION AND AUTHORIZATION FOR MEDICAL TREATMENT

I. **CONSENT FOR MEDICAL PROCEDURES AND TREATMENT:** Permission is hereby granted to the Hospital for such medical procedures, including the taking of photographs for treatment purposes only, as may be deemed necessary by my physician and/or his or her designee. I further consent to treatment by authorized employees or agents who are assigned to my care. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments, examinations, emergency services, or hospital care.

II. **CONSENT FOR BLOOD BORNE INFECTIOUS DISEASE TESTING:** I hereby give my consent to have testing for blood-borne infectious disease, including, but not limited to Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV) if a physician orders such test(s) or if ordered by protocol. The potential side effects of this testing are those encountered during the routine procedure of obtaining blood specimens. The minor complications may include discomfort from the needle stick and slight burning, bleeding or soreness at the site where blood was obtained. The results of this test will become a part of my confidential medical record. I understand that refusal to consent will not result in denial of admission to this Hospital.

III. **NURSING CARE:** This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient needs more intensive nursing care. If the patient's condition requires the service of a special duty nurse, it's agreed that such an arrangement will be made 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 release from any and all liability arising from the fact that said patient is not provided with such additional care. Bedrails will be utilized on all patients for their protection.

IV. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN:** All physicians and surgeons furnishing services to the patient, including radiologist, pathologist, and anesthesiologist are independent contractors with the patient are not employees or agents of the hospital. 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, for the medical and surgical treatment, special diagnostic, or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the physicians.

V. **CONSENT FOR EMERGENCY TREATMENT:** I believe that I am suffering from an emergency medical condition. I know this condition entitles me to an appropriate medical screening and treatment necessary to stabilize my condition. I therefore authorize the Hospital to provide an appropriate medical screening evaluation and treatment, to be performed by or under the supervision of a physician or his/her aide. It has been explained to me that the diagnostic and treatment procedures, which my emergency medical condition legally entitles me, are limited and will include a medical screening examination. It may be necessary for me to select another physician and obtain from him/her a complete diagnosis of my condition and such continued treatment as he/she may prescribe.

VI. **ACKNOWLEDGMENT OF ADVANCE DIRECTIVE / LIVING WILL AND PATIENT HANDBOOK:** I have been offered Advanced Directive and Living Will information and have been informed that it will be given to me at any time at my request during my hospital visit. Patient Rights and Responsibilities and other information relating to my stay are available to me in Patient Registration.

Do you have a Living Will? ☐ Yes ☐ No Durable Power of Attorney? ☐ Yes ☐ No

VII. **CONSENT TO DISCLOSE PATIENT INFORMATION AND OPT OUT OF THE FACILITY DIRECTORY:** The Hospital will not divulge any identifying information about patients without their consent. With this in mind, we need your permission to release information about your presence at the Hospital during your stay. By choosing to opt out of the Facility directory, your location in the hospital will not be released. In addition, you will not receive flowers, cards, phone calls or clergy visits. Please indicate (✓) information that may NOT be included in hospital's directory (please check all that apply)"

☐ Name ☐ Location within Hospital ☐ General Condition ☐ Religious Affiliation

VIII. **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have been given the Hospital's Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the hospital's HIPAA Privacy Officer.

☐ No ☐ Yes – Date Issued: _____

IX. **PATIENT RIGHTS AND RESPONSIBILITIES ACKNOWLEDGEMENT:** I acknowledge that I have received a copy of the Patient Rights and Responsibilities and have had an opportunity to ask questions.

X. **RELEASE OF INFORMATION:** I authorize the Hospital and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during this admission or outpatient visit to any organization which is or may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work-related, I authorize the Hospital to release any information from my medical records to my employer and/or its designee. This authorization specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases including but not limited to blood borne. This authorization to disclose protected health information specifically includes the authorization to disclose any information regarding treatment for a substance abuse disorder, which is protected by Federal law (42 CFR Part 2). Any disclosure of information that is protected by 42 CFR Part 2 pursuant to this authorization is only permitted for purposes of payment or healthcare operations and not for purposes of treatment.

I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses and technicians at the Hospital, home health agencies, ambulance companies, and such other health care agencies involved in my care during and after transfer or discharge from the Hospital. I further acknowledge that my medical records will be utilized in the Hospital's (and the Hospital's affiliates') utilization review, performance improvement, peer review and other similar processes and studies. I also acknowledge that my medical records will also be made available to government agencies as required by law. Information contained in my medical records may be extracted and compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public.

I acknowledge that patient medical records at the Hospital may be stored electronically and made available through computer networks to Hospital personnel, as well as physicians involved in my care and their offices. I also acknowledge that should I be treated at another facility in the area affiliated with the Hospital, my medical records may be made electronically available to the other facility, as well as physicians involved in my care and their offices. This will assist my physician and other caregivers in reviewing past treatment as it may affect my condition and treatment at that time. Facilities, which are not affiliated with the Hospital, and affiliated facilities, which do not have computerized medical records, will not be able to provide this service.

I authorize the release of my social security number in accordance with federal law and regulations to the manufacturer of any medical device I may receive.

XI. **ASSIGNMENT OF BENEFITS:** This assignment of benefits allows the Hospital and/or hospital based physicians to be paid directly by my health insurance carrier or other health benefit plan for the services the Hospital and/or hospital based physicians provide to me, my minor child, or other person entitled to health care benefits for this admission. In return for the services rendered and to be rendered by the Hospital and/or hospital based physicians, I hereby irrevocably assign and transfer to the Hospital and/or hospital based physicians all right, title and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies and health benefit plans from which my dependents or I are entitled to recover. This assignment and transfer shall be for the purpose of granting the Hospital and/or hospital based physicians an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the Hospital and/or hospital based physicians to pursue any such right of recovery. In no event will the Hospital and/or hospital-based physicians retain benefits in excess of

the amount owed to the Hospital and/or hospital based physicians for the care and treatment rendered during this admission. I hold the hospital harmless of any reduction in health care benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: notification, precertification, prior to retrospective authorization, or utilization review of the medical services I receive. I am financially responsible for all charges including deductibles and co-insurance not covered by my policy. I have read and been given the opportunity to ask questions about this agreement of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the Hospital and/or hospital based physicians.

XII. **FINANCIAL AGREEMENT:** In consideration of the services to be rendered to the patient, the undersigned (as parent, guardian, spouse, guarantor, agent or as the patient) individually promises to pay the patient's account at the rates stated in the Hospital's price list (known as the "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this Agreement to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. In the event that the Hospital has to engage an attorney or collection agency to collect any unpaid balances that arise from the treatment consented herein, the undersigned agrees to pay the reasonable attorney's fees and collection expenses incurred by the Hospital. I also agree and consent that the hospital, its assignees and contractors may take all of the following actions regarding amounts owed by me to hospital: (1) contact me by telephone at any telephone number I give the hospital; (2) leave voicemail or answering machine messages for me: (3) send emails or text messages to any account I give the hospital; or (4) use pre-recorded voice messages or an automatic dialing device to contact me.

An estimate of the anticipated charges for services to be provided to the patient is available upon request from the Hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services. By signing below, I agree if payment is not made within 30 days of my first statement, I will have the option to pay the outstanding balance over time, under the conditions set forth by Arkansas Surgical Hospital or its billing company and that, by electing to pay such a balance over time, I consent to and agree with all conditions disclosed on the back of my statement including to the charging of a fee and/or interest on any outstanding balance at a rate not to exceed the maximum rate in effect pursuant to the laws of the State of Arkansas and applicable federal laws at the time the services are rendered.

Each of the undersigned agrees, expressly, whether he/she signs as agent, spouse, guarantor, personal representative, or as 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, terms and charges of the hospital. This agreement in no way relieves any other party from responsibility for payment. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses.

XIII. **MEDICARE PATIENT CERTIFICATION:** I certify that the information given by me in applying for payment under Title XVIII and Title XIX 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 permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

XIV. **PERSONAL VALUABLES:** I understand that the Hospital provides in-room safes for the 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. The Hospital shall not be liable for loss or damage to any other personal property the patient chooses to keep in their room including dentures, glasses, hearing aids, prostheses, etc. I understand and agree that if the Hospital at any time believes there may be a weapon, explosive devices, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Hospital may confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

XV. **TOBACCO USE POLICY:** The Hospital is a tobacco free facility. I understand that while I am a patient at the Hospital I may not use tobacco products.

XVI. **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: _____

Name of Translator: _____

XVII. **NONDISCRIMINATION POLICY:** In accordance with Title VI and VII of the Civil Rights Acts of 1964 and their implementing regulations, Arkansas Surgical Hospital will, directly or through contractual or other arrangements admit and treat all persons without regard to race, color, creed, religion, sex or national origin in its provision of services and benefits, including assignments or transfers within the facility and referrals to or from the facility. Staff privileges are granted without regard to race, color, or national origin (where appropriate).

XVIII. **VISITATION POLICY:** In accordance with The Centers for Medicare and Medicaid Final Rule § 482.13 Condition of participation, Arkansas Surgical Hospital will extend to all persons the ability to visit a patient (unless specifically instructed to not allow visitors by the patient or support person, where appropriate). This includes but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend, race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. At the discretion of the nurse in charge, visitation may be restricted or limited when clinically necessary, if patient care is hindered or disrupted, if visitation may interfere with the care of other patients, if the visitors engage in disruptive, threatening or violent behavior of any kind, or if there may be infection control issues.

XIX. **DISCLOSURE OF PHYSICIAN OWNERSHIP AND OF THE EMERGENCY RESPONSE PLAN:** Arkansas Surgical Hospital has financial relationships with a number of physicians, some of whom have an ownership in the Hospital.

If the physician who recommended the Hospital to you is on the list below, and if his/her financial relationship with the Hospital concerns you, you may be treated at an alternative facility if there is one available. If you would like to discuss your options for treatment at other facilities, or if you have any questions about this disclosure, please ask the person providing you with the form for assistance.

The following physicians have a financial relationship with Arkansas Surgical Hospital:

James R. Adametz, MD	Thomas M. Hart, MD	J. Zachary Mason, MD	Reza Shahim, MD
Scott Bowen, MD	William F. Hefley, MD	Larry Nguyen, MD	Joel Smith, MD
J. Michael Calhoun, MD	Jerry J. Lorio, MD	Clayton H. Riley, MD	Jason G. Stewart, MD
Paul K. Edwards, MD	Kenneth A. Martin, MD	David M. Rhodes, MD	Brad A. Thomas, MD
Jesse D. Abeler, DO	Samuel A. Moore, DO		

To comply with the Centers for Medicare and Medicaid Services (CMS), Arkansas Surgical Hospital is required to disclose to our patients that we do not have a physician on our premises 24 hours per day, 7 days per week. Should you experience an emergency medical condition while at Arkansas Surgical Hospital, our Advanced Cardiac Life Support (ACLS) trained staff members will initiate appropriate treatment based on our policies and procedures, including contacting the on-call physician if required.

I hereby certify and state that I have read, and that I fully and completely understand the above Conditions of Admission and Authorization for Medical Treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily.

_____ _____

Signature of Patient / Parent / Guardian / Conservator — Date / Time

_____

If Other than Patient, Indicate Relationship

_____ _____

Signature of Spouse (If applicable) — Date / Time

_____ _____

Signature of Witness — Date / Time