

CONDITIONS OF ADMISSION TO VAIL VALLEY MEDICAL CENTER

LOCATION

Vail Valley Medical Center Other: _____

CONSENT TO MEDICAL, SURGICAL PROCEDURES: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, rehabilitation, medical or surgical treatment, anesthesia, transfusion, or hospital services rendered to the patient under the general and special instruction of the patient's physician or psychiatrist.

LEAVING AGAINST MEDICAL ADVICE: If I choose to leave the health care facility against or without the advice of my physician, I hereby release the physician, the health care facility, and its agents and employees from all liability for any ill effects which may result.

NURSING CARE: The hospital provides nursing care unless, upon orders of the patients attending physician or surgeon, the patient is provided with more intensive nursing care.

LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS, SURGEONS, PODIATRISTS, RESIDENTS, AND STUDENTS:

You are under the care and supervision of your attending physician, podiatrist, or dentist and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician, podiatrist, or dentist. Certain aspects of your care may be performed by a medical student or resident. Medical students/residents are not employees or agents of the hospital. The activities of medical students/residents are performed under the supervision of an attending physician, not the hospital, and are in furtherance of their graduate medical education. If you object to any aspect of your care being performed by a student/resident, you must make such an objection known to your attending physician immediately. Absent such objection, you will be deemed to have consented to the participation of such student/resident(s) in your care. Certain aspects of your care may be performed by one or more physicians who are "public employees," as that term is defined in the Colorado Governmental Immunity Act, C.R.S. § 24-10-101, et seq. As such, their liability for claims that you may make relating to the care that they provide to you may be limited by the terms of the Governmental Immunity Act. If you object to any aspect of your care being performed by physicians who are subject to the Governmental Immunity Act, you must make such an objection known to your attending physician immediately. Absent such objection, you will be deemed to have consented to the participation of such physicians in your care. It is the responsibility of the patient's physician, podiatrist, or dentist to obtain your informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to you under the general and special instructions of the physician, podiatrist, or dentist. Any questions concerning the nature or results of any examination or treatment should be directed to your attending physician, podiatrist, or dentist.

PERSONAL VALUABLES: It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and that the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, or other articles of unusual value and small size, unless placed therein. In addition, the hospital shall not be liable for the loss of or damage to any other personal property, unless deposited with the hospital for safekeeping.

RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, the hospital may make available to the public certain basic information about the patient, including name, general description of the reason for treatment and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to the hospital for this purpose. Information will be released in accordance to Vail Valley Medical Center's Notice of Privacy Practices. The Notice of Privacy Practices is made available to each patient at time of service. You may request a copy of the Privacy Notice and one will be provided to you.

Your name and location within the hospital will be listed in our patient directory unless you advise us you do not want to be listed in the directory. if you do not want to be listed, please initial here. _____



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The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the hospital may disclose portions of the patient's record including his/her medical record, to any person or entity which is or may be liable for all or any portion of the hospital's charges, including but not limited to government agencies (e.g., Medicare, Medicaid), insurance companies, health care service plans, or workers compensation carriers. The undersigned authorizes the hospital to obtain past prescription history. Special permission is needed to release this information when the patient is being treated for alcohol or drug abuse.

PHOTOGRAPHING/FILMING: Photographing/filming &/or recording may take place during your hospital stay for internal purposes (e.g. education, performance improvement, etc). You will be asked to sign a separate, specific consent for any photographs, films &/or recordings that will be seen or heard by the public (e.g. marketing, commercial filming, brochures, etc.) which shall include the proposed use of the photographs, films &/or recordings.

FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent 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 and terms of the hospital. Should the account be referred to any attorney or collection agency for collection, the undersigned shall pay all actual attorneys' fees and collection expenses. **All delinquent accounts shall bear interest at the highest rate allowed by law.** It is understood that financial liability for all services deemed non-covered by insurance, or elected by the patient, may be billed to the undersigned and the undersigned agrees to accept financial liability for the services.

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of any insurance or other applicable (e.g., Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for this hospitalization or for these outpatient services, including emergency services if rendered. It is agreed that payment to the hospital, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. **Any pre-certification of insurance benefits is the patient's sole responsibility.** The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patient for all services furnished by or in Vail Valley Medical Center, including charges for those physicians for whom Vail Valley Medical Center is authorized to bill in connection with its services.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize the release of all information from the patient's medical record that may be necessary to make reimbursement or payment for any or all the services involved in my care with Vail Valley Medical Center.

The undersigned certifies that he/she has read the foregoing, received a copy thereof and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

Patient / Parent / Guardian / Conservator / Agent _____ **Date:** _____

If other than patient, indicate relationship _____ **Date:** _____

Financial Responsibility Agreement by Person other than the Patient or the Patients Legal Representative.

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

Patient's receipt of the Bill of Rights.

Patient's receipt of Advanced Directive

Patient's receipt of Notice of Privacy Practices

Financially Responsible Party

