

CONSENT FOR ADMISSION

1. APPLICATION FOR ADMISSION AND CONSENT FOR TREATMENT:

I voluntarily consent to the procedures which 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 to me under the general and special instructions of my doctor, and/or his/her assistant or designee. I understand other conditions may be diagnosed which may require treatment during my stay at the Hospital. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me as to the result of any treatment or examinations provided by the Hospital. Any supplies, medical devices or other goods sold or given to me are provided "as is", and St. Paul / Zale Lipshy University Hospitals disclaim any express or implied warranties.

2. AGREEMENTS AND UNDERSTANDINGS:

- a. I have the right to consent or refuse to consent, to any proposed procedures or therapeutic courses.
- b. I will not be involved in any research or experimental procedure without my full knowledge and consent.
- c. I understand that the PHYSICIANS PARTICIPATING IN MY CARE, including my doctor ARE NOT EMPLOYEES OR AGENTS OF ST. PAUL / ZALE LIPSHY UNIVERSITY HOSPITALS, BUT RATHER INDEPENDENT CONTRACTORS who have been granted the privilege of using its facilities for the care and treatment of their patients or are licensed practitioners participating in the care of patients as part of a post graduate medical education program. ST. PAUL / ZALE LIPSHY UNIVERSITY HOSPITALS ARE NOT RESPONSIBLE FOR THE JUDGMENT OR CONDUCT OF ANY PHYSICIAN WHO PROVIDES CARE OR TREATMENT TO ME. The independent relationship of these physicians is not affected by any billing for their services done by St. Paul/Zale Lipshy University Hospitals.
- d. I understand that regardless of my assigned insurance benefits, **I AM RESPONSIBLE FOR AND DO HEREBY EXPRESSLY ASSUME FINANCIAL RESPONSIBILITY FOR** the total charges for hospital, medical and other services rendered. I will receive separate bills for private physician professional fees and services rendered by outside agencies.
- e. I understand that the Hospital has the right to pursue full collection efforts including asset credit checks and litigation.

3. RELEASE OF INFORMATION: I understand that as part of my healthcare, St. Paul/Zale Lipshy University Hospitals' personnel and my physician creates and maintains a record of the care and services provided. I also understand that such information may be used and/or disclosed in the management and delivery of care and services provided by St. Paul /Zale Lipshy University Hospitals to me, as described in the Notice of Privacy Practices.

4. ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENTS:

I hereby assign to St. Paul/Zale Lipshy University Hospitals, and any practitioner providing care and treatment to me, any and all benefits and all interest and rights for services rendered under any insurance policies, including but not limited to Medicare, Medicaid, Tricare, or any reimbursement from a pre-paid health care plan. This means that St. Paul/Zale Lipshy University Hospitals and other practitioners will be entitled to directly receive all insurance payments on my behalf. If my treatment was caused by events which result in legal action, I assign to St. Paul/Zale Lipshy University Hospitals any interest in any claims I may have to the extent necessary to fully reimburse St. Paul/Zale Lipshy University Hospitals for the rendering of services to me. I understand and agree that my account is due in full upon discharge, with allowance made for insurance coverage approved and verified prior to discharge.

5. VALUABLES: I understand that St. Paul/Zale Lipshy University Hospitals do not assume the responsibility for the safekeeping of any personal property that I chose to keep on my person or in my hospital room during my stay, such as, but not limited to money, jewelry, eyeglasses, dentures or hearing aids.

6. NOTICE OF PRIVACY PRACTICES: I acknowledge that I received a Notice of Privacy Practices as part of this visit/admission, or during a previous visit/admission. I understand that a copy of the Notice of Privacy Practice is available to me at any time upon my request.

7. PATIENT RIGHTS AND RESPONSIBILITIES: The Hospital acknowledges that I have certain rights as a patient and I acknowledge I have certain responsibilities as a patient. This information (including how to register complaints I might have) is posted throughout the hospital and is available to me in writing upon my request.

8. TO BE COMPLETED FOR HOSPITAL INPATIENTS AND OUTPATIENTS UNDERGOING INVASIVE PROCEDURES ONLY:

- a. I have a Medical Power of Attorney. Yes No Copy provided? Yes No
- I have a Mental Health Directive. Yes No Copy provided? Yes No
- I have executed an Advance Directive. Yes No Copy provided? Yes No
- b. I have received information about Advance Directives as required by federal law. Yes No
- c. Would you like to discuss Advance Directives with a hospital staff member? Yes No

I understand it is my responsibility to provide a copy of these documents to the Hospital. In the absence of these documents, the provision of care and/or treatment to me will be delivered in accordance with State and/or Federal laws. A Hospital representative is available to discuss the above documents if I decide I would like to prepare and sign them.

I have read the above document and understand its contents. I acknowledge that I am the patient or I am the patient's legally authorized representative, and/or guarantor and consent to the above items and make the acknowledgments hereby made.

Signature (Patient, Guardian or Legally Authorized Representative)

Date

Relationship to Patient** NOTE: (Signature of Parent or legally authorized representative is required if patient is under the age of 18)

Hospital Representative

Date

IMPORTANT MESSAGE FROM MEDICARE

YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare, or covered by your Medicare Health Plan (“your Plan”) if you are a Plan enrollee.
 - You have the right to know about any decisions that the hospital, your doctor, your Plan, or anyone else makes about your hospital stay and who will pay for it.
 - Your doctor, your Plan, or the hospital should arrange for services you will need after you leave the hospital. Medicare or your Plan may cover some care in your home (home health care) and other kinds of care, if ordered by your doctor or by your Plan. You have a right to know about these services, who will pay for them, and where you can get them. If you have any questions, talk to your doctor or Plan, or talk to other hospital personnel.
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YOUR HOSPITAL DISCHARGE & MEDICARE APPEAL RIGHTS

Date of Discharge: When your doctor or Plan determines that you can be discharged from the hospital, you will be advised of your planned date of discharge. You may appeal if you think that you are being asked to leave the hospital too soon. If you stay in the hospital after your planned date of discharge, it is likely that your charges for additional days in the hospital will not be covered by Medicare or your Plan.

Your Right to an Immediate Appeal without Financial Risk: When you are advised of your planned date of discharge, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your Quality Improvement Organization (also known as a QIO). The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You may call Medicare toll-free, 24 hours a day, at 1-800-MEDICARE (1-800-633-4227), or TTY/TTD: 1-877-486-2048, for more information on asking your QIO for a second opinion. If you appeal to the QIO by noon of the day after you receive a noncoverage notice, you are not responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with you. The QIO will decide within one day after it receives the necessary information.

Other Appeal Rights: If you miss the deadline for filing an immediate appeal, you may still request a review by the QIO (or by your Plan, if you are a Plan enrollee) before you leave the hospital. However, you will have to pay for the costs of your additional days in the hospital if the QIO (or your Plan) denies your appeal. You may file for this review at the address or telephone number of the QIO (or of your Plan).

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