11. HEALTH CARE PLAN OBLIGATION: It is your responsibility to comply with the directions of your health plan to ensure payment. If we are a non-contracted provider, you agree that you are individually responsible for full charges for services rendered.

12. ADVANCE DIRECTIVE: Do you have a current Advance Directive for Health Care? ❑ Yes ❑ No

If yes, it is important for you to provide a copy for our records. Name of advance directive agent and contact information if copy not provided: _____

If no, do you want more information? Yes, information received [ ] Initials No, information declined [ ] Initials Family members or surrogates receiving information on behalf of an incapacitated patient are requested to provide the information to the patient in the event he or she regains capacity.

13. ASSIGNMENT OF INSURANCE BENEFITS: Whether you sign as agent or as patient, you assign and authorize direct payment to the hospital of all insurance, disability and contract benefits for services rendered. You understand you are financially responsible for charges not covered by this assignment. This assignment cannot be revoked.

14. PUBLICATION OF DIRECTORY INFORMATION: Unless otherwise indicated below, the Hospital has your permission to release general information to anyone who asks for you by name. This information allows visitors and delivery personnel to find you in the hospital. Any restrictions may prevent family and friends from reaching you while you are in the hospital. Your information will be included in the hospital directory unless you indicate otherwise by initialing below.

DIRECTORY INFORMATION

Room Number [ ] initial if not approved General Condition [ ] initial if not approved Religious Affiliation (Released to Spiritual Care Providers Only) [ ] initial if not approved.

15. Initial here [ ] if not approved. **LIMITED POWER OF ATTORNEY:** You appoint Sharp HealthCare as agent and Attorney in Fact to complete and file any required claim forms or related documents and to do all things you could do to obtain direct payments from any insurance or healthcare benefits available or from the California Medical Assistance Program, in connection with treatment and hospitalization. Sharp HealthCare is not required to file any claim forms.

16. Initial here [ ] if not approved. **NEWBORN PHOTOGRAPHY:** The taking of pictures of my newborn child or children for possible purchase by me is approved.

17. PERSONAL VALUABLES/BELONGINGS: The Hospital maintains a safe for the safekeeping of money and valuables. The Hospital accepts no liability for loss of, or damage to, any item you bring to the Hospital, unless you first deposit it with the hospital for safekeeping. The liability of the Hospital for loss of, or damage to, all items you deposit with the Hospital for safekeeping is limited to five hundred dollars ($500.00) unless you are given a written receipt for a greater amount.

[ ] initial here

18. OPTION TO DECLINE COPY OF THIS DOCUMENT: A copy of this agreement, and your rights and responsibilities, is included in your medical record and is available to you on request. You can also have a copy now. [ ] Initial here to decline a copy at this time.

19. CONTACT INFORMATION: The undersigned expressly consents and agrees that Sharp Rees-Stealy/Sharp HealthCare, its business associates, and other third parties, including debt collectors, may send periodic electronic communications for any lawful purpose, including routine business and/or marketing purposes, at any email address or phone number he/she provides. Messages may be sent by text (SMS), email, automatic telephone dialing systems (auto-dialer), prerecorded messages or live operator calls. Message frequency will vary. Message and data rates apply. The undersigned may opt out of receiving further automated, electronic communications at any time by texting STOP or calling 1-800-827-4277. Whether the undersigned agrees to receive these messages will not affect care in any way. Visit www.sharp.com/terms for complete Terms of Use.

The undersigned certifies that he/she has read the foregoing, been offered 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 the above and accept its terms. All references to "you" in this document include both the patient and any other person signing as the patient's representative, as indicated by context.

Date	Time	Patient/Relative/Guardian/Conservator	Relationship (if not patient)	Witness

Financial Responsibility Agreement by Person other than the 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 Care Service Plan Obligation Provisions above.

Date	Time	Patient/Relative/Guardian/Conservator	Relationship (if not patient)	Witness

PATIENT IDENTIFICATION

ADMISSION AGREEMENT FOR INPATIENT AND OUTPATIENT SERVICES

1. GENERAL CONSENT TO HOSPITAL SERVICES: You consent to all hospital services rendered under the general and special instructions of your physician(s), and to the taking of photographs and videos of you for medical treatment, scientific, education, quality improvement, safety, identification or research purposes, at the discretion of the hospital and your caregivers and as permitted by law. In the event a healthcare worker is exposed to your blood or body fluid during your hospitalization, we may test a sample of your blood for diseases that might be communicable. Teaching programs for various healthcare disciplines are conducted through colleges, universities and high schools in some areas of this hospital. Students and residents of these programs may participate in your care.

2. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS: All physicians and surgeons furnishing services to you while you are on any part of the hospital property, including the emergency room and any inpatient or outpatient areas, are independent practitioners. They are not employees or agents of the Hospital and have been granted the privilege of using the hospital for the care and treatment of their patients; for convenience the Hospital may process bills for their professional services. The Hospital is not legally responsible for the acts or omissions of these independent practitioners. Your physicians are responsible for obtaining your informed consent, when necessary, for surgical or special procedures.

Initial here [ ] I acknowledge that the physicians are NOT employees of the hospital.

3. NURSING CARE: This Hospital provides only general nursing care unless your physician orders more intensive nursing or other care. If your condition warrants the service of a special duty nurse, you agree that those services must be arranged by you or your legal representative. The Hospital is not responsible for failure to provide special duty nurse services, and accepts no liability from the provision or absence of such additional care.

4. MODIFICATIONS: The Hospital's employee processing this document is not authorized to make or accept modifications to or deletions from its language. You acknowledge that any modifications, including deletions, made by you are not binding on the Hospital. Refusal to sign this document may not relieve you from financial responsibility for services you accept from the Hospital and/or independent practitioner physicians.

5. PATIENT RIGHTS: You have been offered a list of Patient Rights and Responsibilities.

6. CONCERNS/GRIEVANCE PROCESS: You are encouraged to contact your nurse or the Patient Relations department with complaints or concerns about your care. If your concerns and/or complaints are not resolved to your satisfaction, you may file a formal grievance with Patient Relations or Administration and a hospital Grievance Committee will review your issues. For additional information on filing complaints about any issue, please refer to patient rights and responsibilities in this document.

7. RELEASE OF INFORMATION: How the Hospital uses and discloses your personal and medical information is described in the Notice of Privacy Practices. Your signature below acknowledges your receipt of a copy of this Notice. Additional copies of the Notice may be requested at this time. Note: "No Information" status will automatically be given to any person admitted for psychiatric, substance abuse or mental health treatment or attempted suicide, any person admitted while in the custody of law enforcement officers, or any person admitted to Behavioral Health Services. Any other person may add restrictions or request "No Information" status at any time, and any person may request that "No Information" status be discontinued at any time.

8. ASSIGNMENT OF INSURANCE BENEFITS FOR PHYSICIAN SERVICES: Your signature below authorizes direct payment to those physicians on the Hospital Medical Staff who render care to you while you are at the Hospital. This authorization cannot be revoked. You certify that you agree to this assignment of benefits, that you understand (as described in paragraph two (2)) that your relationship to your physicians is independent of your relationship to the Hospital, and that you have full authority to execute this agreement and accept its terms. You are hereby offered a copy of this form. NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, (800) 633-2322 www.mbc.ca.gov.

9. MEDICAL SUPPLIES PROVIDED TO MEDICARE PATIENTS: If you are a patient eligible for Medicare Part A benefits, you acknowledge that title to all tangible medical related products and devices provided to you or consumed while providing services to you in the hospital ("Medical Supplies") vests in you when the first of the following occurs: when the Medical Supplies are provided to you or consumed while the hospital is providing services to you; when the hospital begins to process the Medical Supplies; or when the hospital receives payment from Medicare.

10. FINANCIAL AGREEMENT: You agree, whether you sign as agent or as patient, that in consideration of the services to be rendered to the patient, you hereby individually obligate yourself to pay all hospital bills in accordance with the rates as indicated in the hospital charge description master and terms of the hospital to include service charges and/or interest bearing payment plans. The hospital, or other entity contracting with the hospital, may obtain credit reports from national credit bureaus. Should the account be referred to an attorney or collection agency for collection, you shall pay all related fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

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21. Designate visitors of your choosing, regardless of their relationship to you. *To the extent you are unable to make your wishes known, the hospital will use its best judgment, and will allow anyone who lives in your household to visit you.*
    However:
    - Visitors may be restricted to certain times and places.
    - Hospital staff and affiliated physicians reserve the right to refuse a particular visitor if they reasonably determine that the individual could endanger the health or safety of anyone on the premises, or could disrupt hospital operations.
22. Examine (and receive an explanation of) the hospital's bill, regardless of the source of payment you use.
23. Be free of discrimination on the basis of race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language, immigration status, age, economic status, educational background, and the source of payment for care as set forth in Section 51 of the Civil Code.
24. File a written grievance with hospital administration. *Grievances are filed in writing with the hospital Patient Relations Department, which will consider them and respond within 30 days. If you are not satisfied with the determination, you may request in writing that the Patient Relations Department forward your grievance to the hospital grievance committee. This committee will review your request and respond within 90 days. All responses will contain the steps taken to investigate your grievance, the results of that stage of the grievance process, the date that the process was completed, and the name of a contact person with whom you may discuss any further questions or concerns. Concerns regarding quality of care will automatically be referred to the appropriate utilization and/or quality control peer review organization.*
25. You also have the right to file a complaint with the California Department of Public Health (CDPH) whether or not you use the Hospital's complaint management/grievance process at: CDPH – Licensing and Certification Program, San Diego District Office,7575 Metropolitan Drive, Suite 211, San Diego, CA 92108, or via telephone at (619) 278-3700 and (800) 824-0613. *You also have the right to file a complaint concerning discrimination by a health care facility with the Department of Fair Employment and Housing at https://www.dfeh.ca.gov/complaint-process/file-a-complaint/, or call the Communication Center at 1-800-884-1684 (voice), 1-800-700-2320 (TTY) or California's Relay Service at 711, or write to: 2218 Kausen Drive, Suite 100, Elk Grove, CA 95758.*
26. Patient Safety Concerns can be reported to The Joint Commission at www.jointcommission.org, using the "Report a Patient Safety Event" link, or by fax to 630-792-5636, or by mail to Office of Quality and Patient Safety, The Joint Commission, 1 Renaissance Boulevard, Oakbrook Terrace, IL 60181.
27. The Medical Board of California, the Board of Podiatric Medicine and the Osteopathic Medical Board of California are the only authorities that may take disciplinary action against the license of a physician, surgeon or podiatrist. Contact the Medical Board of California at 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815, 1-800-633-2322, email: Complaint@mbc.ca.gov and/or the California Board of Podiatric Medicine at 2005 Evergreen Street, Suite 1300 Sacramento, CA 95815, 1-916-263-2647, email: pmbc@dca.ca.gov and/or the Osteopathic Medical Board of California at 1300 National Drive Suite 150 Sacramento, CA 95834-1991, 1-916-928-8390, E-mail: Osteopathic@dca.ca.gov.

YOU HAVE THE RESPONSIBILITY TO:

1. Know and follow applicable hospital rules and regulations, as conveyed to you in writing or through reasonable verbal direction by hospital staff and affiliated physicians.
2. Provide information about past illnesses, hospitalizations, medications and other matters relating to your health that may be important.
3. Cooperate with all hospital personnel and ask questions of your doctors and nurses when you do not understand directions or expectations that have been conveyed to you.
4. Be considerate of other patients and hospital personnel, assist in the control of noise and comply with rules regarding smoking, visitors and use of common areas.
5. Explain to your visitors that they must also comply with all of the same hospital rules and regulations that apply to you with regard to protecting the health and safety of others, and with regard to the safe and efficient operation of the hospital.
6. Provide information necessary to process your chosen form of payment, recognizing that you are responsible for your hospital bills and any additional charges for professional services from your physicians and other non-hospital providers.
7. Help your doctors and care team members in their efforts to return you to health by following their instructions.
8. Be respectful of the property of others and that of the hospital.
9. Understand that the hospital is not responsible for your personal property unless it is locked in the hospital's safe.
10. Provide a copy of any advance health care directive you may have in effect.
11. Advise your doctor, care team, or Patient Relations Department of any dissatisfaction you have with care or hospital services.

If you have any questions about your rights and responsibilities, please ask your doctors or any Sharp HealthCare employee for assistance, or contact the hospital's Patient Relations Department.

This document is based on the requirements of The Joint Commission and Section 70707 of Title 22 of the CA Admin. Code; CA Health & Safety Code sections 1262.6, 1288.4 and 124960; part 482 of Title 42 of the CFR; and parts 80, 84 and 91 of Title 45 of the CFR.

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PATIENT RIGHTS AND RESPONSIBILITIES

As a patient at Sharp HealthCare, you have both rights and responsibilities regarding your treatment.

YOU HAVE THE RIGHT TO:

1. Receive respectful consideration of your care needs, your physical comfort and your personal values and beliefs.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the physician who has primary responsibility for coordinating your care, and the names and professional relationships of other physicians and non-physicians who will see you.
4. Request or refuse treatment, and to permanently leave the hospital even against the advice of your physicians, to the extent permitted by law. *You do **not**, however, have the right to expect or compel treatment or services that are medically inappropriate. A biomedical ethics committee is available to help with difficult situations and in cases of conflict between your wishes and your physicians' professional judgment. Your physicians or any hospital employee can help you contact this committee.*
5. Receive information about your health status, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. *You have the right to actively participate in the development and implementation of your plan of care. You also have the right to participate in examining ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.*
6. Decide what medical care you will accept, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. *Except in emergencies, this information shall include a description of the procedure or treatment; the medically significant risks involved; alternate courses of treatment or non-treatment, and the risks involved in each; and the name of the person(s) who will carry out any procedure or treatment.*
7. Receive reasonable responses to any reasonable requests for service that you make.
8. Be advised if your physician or care team proposes to engage in or perform clinical research that may affect your care or treatment. *You have the right to decline to participate in such research without fear of reprisal.*
9. Receive appropriate assessment and management of your pain, including information about pain and pain relief measures that may be available to you, and participate in pain management decisions. *You may request the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe, chronic or intractable pain. Your physician may refuse to prescribe various modalities, including opiates, but if so will refer you to a physician who specializes in the use of such medications.*
10. Formulate advance health care directives. *This includes designating a decision-maker who will act if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding your care.*
11. Have all of your rights as a patient, to the extent allowed by law, apply to the decision-maker you designate or who is designated by law.
12. Have your personal privacy respected. *You have the right to be told the reason for the presence of any individual, and to have visitors leave prior to an examination and when treatment issues are being discussed.*
13. Receive confidential treatment of your records and communications about your care outside the hospital.
14. Access information contained in your records, within the boundaries allowed by the law.
15. Provide a written addendum, not to exceed 250 words, to your medical records should you believe they are inaccurate or incomplete.
16. Receive care in a safe setting, free from verbal and physical abuse and harassment. *You have the right to access protective services, including those provided by agencies that review allegations of abuse.*
17. Be free from restraints or seclusion of any form intended as a means of discipline, coercion, retaliation, or for the mere convenience of staff or physicians.
18. Receive reasonable continuity of care, and to know in advance the time and location of appointments.
19. Be informed by your physicians and care team of continuing health care requirements following your discharge from the hospital. Be informed, and if authorized, to have friends or family informed, of continuing care requirements following discharge from the hospital. *Upon request, this information can also be provided to those you designate.*
20. Receive reasonable information from hospital staff and physicians concerning which hospital rules and policies apply to your conduct while a patient, and to the conduct of your visitors.

11. HEALTH CARE PLAN OBLIGATION: It is your responsibility to comply with the directions of your health plan to ensure payment. If we are a non-contracted provider, you agree that you are individually responsible for full charges for services rendered.

12. ADVANCE DIRECTIVE: Do you have a current Advance Directive for Health Care? ❑ Yes ❑ No

If yes, it is important for you to provide a copy for our records. Name of advance directive agent and contact information if copy not provided: _____

If no, do you want more information? Yes, information received [ ] Initials No, information declined [ ] Initials Family members or surrogates receiving information on behalf of an incapacitated patient are requested to provide the information to the patient in the event he or she regains capacity.

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DIRECTORY INFORMATION

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[ ] initial here

18. OPTION TO DECLINE COPY OF THIS DOCUMENT: A copy of this agreement, and your rights and responsibilities, is included in your medical record and is available to you on request. You can also have a copy now. [ ] Initial here to decline a copy at this time.

19. CONTACT INFORMATION: The undersigned expressly consents and agrees that Sharp Rees-Stealy/Sharp HealthCare, its business associates, and other third parties, including debt collectors, may send periodic electronic communications for any lawful purpose, including routine business and/or marketing purposes, at any email address or phone number he/she provides. Messages may be sent by text (SMS), email, automatic telephone dialing systems (auto-dialer), prerecorded messages or live operator calls. Message frequency will vary. Message and data rates apply. The undersigned may opt out of receiving further automated, electronic communications at any time by texting STOP or calling 1-800-827-4277. Whether the undersigned agrees to receive these messages will not affect care in any way. Visit www.sharp.com/terms for complete Terms of Use.

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Date	Time	Patient/Relative/Guardian/Conservator	Relationship (if not patient)	Witness

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Date	Time	Patient/Relative/Guardian/Conservator	Relationship (if not patient)	Witness

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