

CONDITIONS OF ADMISSION/CLINIC VISIT

MEDICAL CONSENT: I agree to the procedures and treatments that may take place on me/patient while a patient in the Hospital/Clinic. These procedures and treatments may include physical exams, laboratory and other tests, x-rays, pain relief, routine/simple nursing, surgical and other medical services, procedures and treatments, and telehealth services. I understand that Hospitals/Clinics run by the County of Los Angeles may be teaching facilities. I understand and agree that interns, residents, and fellows supervised by an attending physician may care for me/patient. I understand and agree that I may receive care from a physician who does not hold a physician's and surgeon's certificate but who is qualified and certified by the California Medical Board to provide care in a special program as a visiting professor or faculty member. I also agree that medical students, dental students, student nurses, and any other students approved by the Hospital/Clinic may help in, or observe, my/patient's care. I agree that the Hospital/Clinic may use and get rid of any tissue, organ, matter or other item removed from my/patient's body.

PICTURES/VIDEO/AUDIO: I agree that pictures, video or other images, or audio recordings of me/patient may be taken for treatment purposes and for the Department of Health Services' healthcare operations, including peer review, quality improvement, training and education.

HOSPITAL/CLINIC RULES: I agree that I/patient will follow the rules and accept that the Administrator/Director of the Hospital/Clinic will be the only person who will decide if Hospital/Clinic rules are being followed. I agree that if I/patient fails to follow the rules, I/patient may be asked to go home or be discharged from the Hospital/Clinic.

NURSING CARE: I understand and agree that the Hospital/Clinic provides only general duty nursing care unless, upon orders from my/patient's doctor, I/patient will be given more intensive nursing care.

MATERNITY PATIENTS: If I deliver an infant(s) while a patient in this hospital, I agree that these same Conditions of Admission apply to the infant(s).

RELEASE OF INFORMATION: I understand that my/patient's health information is protected by state and federal law. Unless the law says it is allowed, a separate form must be signed for the Hospital/Clinic to use my/patient's health information.

USE OF PATIENT INFORMATION TO OBTAIN PAYMENT FOR HOSPITAL/CLINIC SERVICES: I agree that the Hospital/Clinic may share any part of my/patient's records, including the medical record, with someone who is responsible for paying the Hospital/Clinic bill. This might be an insurance company, health care plan or worker's compensation company. If a patient is being treated for alcohol or drug abuse, HIV/AIDS, or is for mental health problems, special permission may be needed to share this information.

FINANCIAL AGREEMENT: I understand and agree that I am the person responsible for paying the Hospital/Clinic if the patient does not have insurance, at the regular rates and terms of the Hospital/Clinic. If I do not pay and the bill goes to collections, I agree to pay any attorney's fees and collection expenses. If my account is late, I agree that I can be charged interest at the legal rate.

MEDI-CAL/MEDICARE: If I filled out Medi-Cal or Medicare Program forms, I agree that I filled out the forms truthfully. I agree to release information needed to complete this request. I agree to allow payment to be made directly to the County of Los Angeles Department of Health Services. I agree to pay any leftover charges that I am legally responsible for. I give the rights that I have to payment under Medicare Part A or B for care at Hospital/Clinic, including any physician services to Hospital/Clinic.

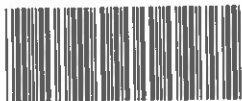
ASSIGNMENT OF INSURANCE BENEFITS: I agree to allow patient's insurance company to pay the County of Los Angeles directly. This includes Medical Groups associated with the County. I agree to pay any leftover charges not paid by the insurance company.

PERSONAL VALUABLES IN THE HOSPITAL: I understand that the Hospital has a safe for money and valuables. The Hospital is not responsible for money or valuables that are not put in the safe. If I do not put money or valuables in the safe, they may be stolen or lost. I understand that I should leave my money and valuables at home. I understand that the Hospital is only responsible for up to \$500 worth of lost/stolen items in the safe, unless

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NAME

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T-HS62A

I have a receipt from the Hospital for a larger amount.

PROPOSITION 65 WARNING: Proposition 65 requires the Governor to publish a list of chemicals "known to the State to cause cancer, birth defects or reproductive harm." It also requires California companies, including health care providers, to warn the public of potential exposures to these chemicals. Some of the chemicals on the Governor's list are used by health care facilities, including the Department of Health Services facilities. You may be exposed to some of the chemicals during your stay at the Hospital/Clinic. In addition to these chemicals, some drugs used to treat patients include chemicals known to the State to cause cancer, birth defects, or reproductive harm. Please consult your health care provider or pharmacist at Hospital/Clinic for specific information about any drugs prescribed for you. If you have questions regarding this information, please visit the Office of Environmental Health at www.oehha.ca.gov or call (916) 445-6900.

NOTICE TO CONSUMERS: If you have concerns about patient care and safety that the Hospital/Clinic has not addressed, you are encouraged to contact Hospital/Clinic administration. If the concerns cannot be resolved through Hospital/Clinic administration, you may contact The Joint Commission at (800) 994-6610 or complaint@jointcommission.org. The medical doctors at this facility are licensed and regulated by the Medical Board of California. For additional information, or to file a complaint about a medical doctor (MD), contact the Medical Board of California at (800) 633-2322 or www.mbc.ca.gov. The physician assistants at this facility are licensed and regulated by the Physician Assistant Committee. For additional information, or to file a complaint about a physician assistant (PA), contact the Physician Assistant Committee at (916) 561-8780 or www.pac.ca.gov.

I AM SIGNING THIS TO SAY I UNDERSTAND AND AGREE TO ALL THE ABOVE STATEMENTS. I HAVE BEEN GIVEN THE CHANCE TO ASK QUESTIONS AND TO HAVE MY QUESTIONS ANSWERED. I AM AUTHORIZED AS THE PATIENT OR THE PATIENT'S REPRESENTATIVE TO AGREE TO THESE THINGS. I HAVE RECEIVED A COPY OF THIS AGREEMENT.

WITNESS SIGNATURE	PATIENT OR RESPONSIBLE PERSON SIGNATURE	RELATIONSHIP TO PATIENT	DATE	TIME
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ADDRESS	STREET	CITY	ZIP
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(Boxes below to be completed by institution's staff.)

MINOR CONSENT: ☐ Emancipated (FC 7002-7140), ☐ Self-sufficient (FC 6922), ☐ Pregnant (treatment/prevention) (FC 6925),
☐ Active Duty Armed Forces (FC 7002), ☐ Reportable CD (FC 6926), ☐ Care for Rape (FC 6927), ☐ Care for Sexual Assault (FC 6928),
☐ Care for Alcohol/Drug Abuse (FC 6929), ☐ Mental Health Treatment/Counseling Services (FC 6924)

ADVANCE DIRECTIVE: (See attached if applicable) ☐ Brochure on Patient Self Determination Act given to patient.

Patient has Advance Directive: ☐ Yes ☐ No ☐ Unknown.

If yes, ☐ copy placed on chart or, ☐ advised patient to provide copy to physician.

If no, does patient want further information on Advance Directive ☐ Yes ☐ No

PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST)

Patient has completed POLST form: ☐ Yes ☐ No ☐ Unknown.

If yes, ☐ copy placed on chart or, ☐ advised patient to provide copy to physician.

If no, does patient want further information regarding POLST ☐ Yes ☐ No

Patient has Organ Donor Card: ☐ Yes ☐ No

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FILE IN MEDICAL RECORD

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