

# Salem Health

## Conditions of Admission



**MEDICAL CONSENT:** I consent to the treatment or procedures that may be performed during this hospitalization or on an outpatient basis including emergency treatment, laboratory procedures, x-ray examinations, anesthesia, physical therapy, nursing care or other or other medical or surgical treatment or hospital services rendered under the general and special instructions of my licensed health care providers. I permit Salem Health Hospitals and Clinics (SH) to release information or copies of my medical record to my primary care provider, any referring provider, skilled nursing facility or other health care facility to which I may be transferred. I understand that all licensed professional healthcare providers that care for me are responsible and liable for their own actions. I acknowledge that SH cannot guarantee the outcome of treatment.

**SOME PROVIDERS ARE INDEPENDENT MEDICAL PRACTITIONERS:** I understand that some of the providers caring for me, including the radiologist, pathologist, anesthesiologist and others, are independent medical practitioners and are not employees or agents of SH. These providers will bill separately for their services. I understand that I will be under the care and supervision of my attending providers and SH and its nursing staff will carry out the instructions of the providers. My provider will obtain my informed consent, if indicated, to perform surgical treatment, special diagnostic or therapeutic procedures, or certain hospital services rendered to me.

**PHOTOGRAPHING, VIDEO & AUDIO RECORDING:** I may be photographed or video recorded to document my medical treatment or condition, or for quality review or safety. I understand that patient/family initiated photographing, video and audio recording is a privilege, not a right. I must gain permission from the provider prior to using my own personal video/audio recording devices or photographing any part of the care or treatment.

**FINANCIAL AGREEMENT:** I agree to pay for all services and supplies rendered to me in accordance with the rates and financial policies in effect on the day(s) I receive care. I understand I am responsible for charges not covered by my insurance. I understand I am responsible for any deductible, co-pay and coinsurance. I will be responsible for charges that apply if my insurance requires a referral from my primary provider and I do not get it.

**FINANCIAL COUNSELING:** Financial counseling is available to determine the ability to pay and/or eligibility for a possible charity discount. A credit report may be obtained to verify financial information. All accounts are payable in full at time of billing unless there is valid insurance coverage. Certified Community Partner Assistants are available for Oregon Health Plan screening/enrollment assistance. If insurance denies payment, the balance may become my responsibility. I agree to pay SH's reasonable costs for collecting payments if I do not pay on time the amounts I am responsible for paying. These collection costs may include attorney fees whether or not legal action has been filed or appealed.

**ASSIGNMENT OF INSURANCE BENEFITS:** I assign to SH the right to receive benefit payments directly from my health insurance or health plan for reimbursement of the hospital, providers and other services I receive at SH. I authorize payment directly to providers and laboratories for related charges. I am responsible for all charges not covered by my insurance policy(s). If I am entitled to Medicare or Medicaid benefits under Title XVIII of the Social Security Act, I request assignment of the benefit directly to SH. I understand that this assignment is final.

**RESPONSIBILITY FOR ALL PERSONAL PROPERTY:** I am responsible for the things I bring to SH including:

- Valuables: money, debit cards, jewelry, etc.
- Personal property: glasses, dentures, clothing, etc.
- Documents: ID, insurance forms, notes from my job, etc.
- Electronics: phones, computers, video games, etc.
- Any other thing I bring with me not listed above.

SH has a safe I can put my things in. If my things are lost or damaged, SH is not responsible for replacing them. If I bring electronics, SH cannot promise they will work. I will not bring medical devices into SH. Any left behind items must be picked up within 30 days or SH will dispose of them according to its rules.

**SALEM HEALTH HOSPITALS AND CLINICS ARE SMOKE FREE** - I cannot smoke or use e-cigarettes anywhere at SH. This includes outside walkways, sidewalks and parking lots/structures. If I choose to smoke, I must leave SH property. If I leave, I am responsible for my own safety.

**HEALTHCARE WORKER EXPOSURE/BLOOD TESTING:** If any healthcare worker is exposed to my blood or other bodily fluids, I permit SH to test it. I understand that SH will test for things like Hepatitis B/C, HIV, or other communicable diseases.

**I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS.**

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Print name

If you are not the patient, identify your relationship to the patient:

- Healthcare power of attorney
- Spouse
- Adult child
- Parent
- Legal guardian

**NOTICE OF PRIVACY PRACTICES:** I was offered the Notice of Privacy Practices, which describes how SH may use and disclose my healthcare. I understand that my information may be disclosed electronically. I can contact the Privacy Officer if I have questions or complaints. **Patient Initials** \_\_\_\_\_

**PATIENT RIGHTS AND RESPONSIBILITIES:** I was offered the Patient's Rights and Responsibilities information sheet. **Patient Initials** \_\_\_\_\_

**PATIENT LABEL**