Salem Health Hospitals and Clinics

Conditions of Admission
Inpatient/Outpatient Services

Salem Health® Hospitals & Clinics

MEDICAL CONSENT: I consent to the care and treatment I may receive during this hospitalization or as an outpatient. This may include emergency care, medical or surgical treatment, tests (such as laboratory and imaging), and other services recommended by my licensed providers. My provider will obtain my informed consent, when required, for surgery, specialized procedures, or certain treatments. I understand that I will be under the care of my attending providers, Salem Health (SH), and its nursing staff will carry out their instructions. I understand that each licensed provider is responsible for their own care and that outcomes cannot be guaranteed.

CONSENT TO TELEHEALTH: I consent to the use of telehealth for the delivery of health care services. Telehealth may involve the use of audio, video, or other electronic communications to interact with me/my chosen representative, consult with health care providers, and/or review my medical information for the purpose of diagnosis, therapy, follow-up, and/or education.

PHOTOGRAPHING, VIDEO & AUDIO RECORDING: I understand that I may be photographed or audio/video recorded to support my care, safety, or quality review. I also understand that any patient or family-initiated recording is a privilege, not a right. I will obtain provider permission before using personal devices to photograph or record any part of care or treatment.

INDEPENDENT MEDICAL PROVIDERS: I understand that some of the providers involved in my care, such as emergency physicians, intensivists, pathologists, radiologists, and others, may be independent practitioners and not employees or agents of SH. These providers may bill separately for their services.

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.

NO SURPRISES BILLING RIGHTS: I understand and that I have protections against certain unexpected medical bills under federal law. I acknowledge that I have been offered the No Suprises Billing Rights disclosure notice and understand a paper copy is available upon request.

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.

MEDICAL FINANCIAL COUNSELING: I understand that financial counseling is available to help determine my ability to pay and possible eligibility for financial assistance. A credit report may be used to verify financial information. Payment is due in full unless covered by valid insurance. Assistance with Oregon Health Plan screening and enrollment is available through Certified Community Partner Assisters. If my insurance does not pay, I understand that I may be responsible for the balance. If amounts I owe are not paid on time, I agree to pay reasonable collection costs, which may include attorney fees.

PERSONAL PROPERTY: I understand that SH encourages patients to leave all personal property at home. I am responsible for my personal property, including, but not limited to: Valuables (e.g. money, debit cards, jewelry); Personal items (e.g. glasses, dentures, clothing); Documents (e.g. identification, insurance forms); Electronics (e.g. cell phones, laptops, video games); and Anything else I bring to SH that is not listed above.

I will not bring personal medical devices. I understand that a safe may be available for storage. SH is not responsible for lost or damaged personal property and cannot guarantee that personal electronics may function. Any items left behind must be picked up within 30 days or they may be disposed. SH reserves the right to search belongings as permitted by policy.

SMOKE FREE CAMPUS: I understand that cannot smoke or use e-cigarettes anywhere at SH. This includes outside walkways, sidewalks and parking lots and 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. I understand that SH will test for things like Hepatitis B/C, HIV, or other communicable diseases.

SUPPORT PERSONS: I understand that if I need assistance with communication, medical decisions, or daily activities due to a disability, I may designate at least three support persons, and have at least one with me in the emergency department, and during my hospital stay. I understand that support persons must follow hospital safety protocols.

LANGUAGE ASSISTANCE & AUXILIARY AIDS: I understand that if I need assistance with communication due to a disability or limited English proficiency, I may request free language assistance services or auxiliary aids. These services may include interpreters, translated materials, and other communication supports. I understand that I may request these services at any time.

RELEASE OF INFORMATION/TRANSFER OF RECORDS: I permit 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 to, and as outlined in the Notice of Privacy Practices.

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 RIGHTS AND RESPONSIBILITIES: I was offered the Patient's Rights and Responsibilities information sheet.

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

WHITE – ORIGINAL YELLOW – PATIENT

PATIENT LABEL

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