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 I am agreeing to receive care at a Hospital/Clinic owned and run by the County of Los Angeles. 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 Hospitals'/Clinics' 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/Clinic, 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 and/or Department of Public Health. 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 I have a receipt from the Hospital for a larger amount.

MRUN

NAME

DOB/GENDER

CONDITIONS OF ADMISSION / CLINIC VISIT

PATIENT RIGHTS

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences.

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 licensed health care practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating your care and the names and professional relationships of physicians and non-physicians who will see you.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in 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.

5. Make decisions regarding medical care, 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 risk involved in each, and the name of the person who will carry out the procedure or treatment.

6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the health facility even against the advice of members of the medical staff, to the extent permitted by law.

7. Be advised if the health facility/licensed independent practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

8. Reasonable responses to any reasonable requests made for service.

9. Appropriate assessment and management of your pain, information about pain, pain relief measures, and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Health facility staff and practitioners who provide care in the facility shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf. Complaints about the advance directive requirements may be made to the California Department of Public Health (see contact information below).

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reasons for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

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 and Department of Public Health 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 to report concerns regarding Department of Health facilities. The medical doctors at this Hospital/Clinic 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 Hospital/Clinic 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. IF REQUESTED, I HAVE RECEIVED A COPY OF THIS AGREEMENT.

WITNESS SIGNATURE PATIENT OR RESPONSIBLE PERSON SIGNATURE RELATIONSHIP TO PATIENT DATE TIME

ADDRESS STREET CITY ZIP

MRUN

NAME

DOB/GENDER

CONDITIONS OF ADMISSION / CLINIC VISIT

12. Confidential treatment of all communications and records pertaining to your care and stay in the health facility. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

13. Receive care in a safe setting, free from mental, physical, sexual, or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form as used as a means of coercion, discipline, convenience, or retaliation by staff.

15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

16. Be informed by the physician, or delegate of the physician, of continuing health care requirements and options following discharge from the health facility. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information also.

17. Know which health facility rules and policies apply to your conduct while a patient.

18. Designate a support person, as well as visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, or registered domestic partner status, unless: no visitors are allowed; the health facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the health facility; you have told the health facility staff that you no longer want a particular person to visit. However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform you (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

19. Have your wishes considered if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the health facility's policy on visitation. At a minimum, the health facility shall include any persons living in your household and any support person pursuant to federal law.

20. Examine and receive an explanation of your bill regardless of the source of payment.

21. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation, gender identity/expression, disability, medical condition, marital status, registered domestic partner status, genetic information, citizenship, primary language, immigration status (except as required by federal law) or the source of payment for care.

22. File a grievance. If you want to file a grievance with this health facility, you may do so by writing or by calling the Patient Relations Department/Patient Advocate. Your grievance will be reviewed and you will be provided with a written response. The written response will contain the name of a person to contact at the health facility, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).

23. File a complaint with the California Department of Public Health regardless of whether you use the health facility's grievance process. The California Department of Public Health's phone number and address is 800-228-5234, 681 S Parker St., Suite 200 Orange, CA 92868.