HOAG ORTHOPEDIC INSTITUTE

This is a legal document.
Changes will not be accepted on this form

CONDITIONS OF ADMISSION

By signing below, I acknowledge that I am the patient, the patient's legal representative, or a person otherwise authorized to sign on the patient's behalf. I agree to the following Conditions of Admission and related terms to the extent permitted by applicable federal and California law.

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I consent to the medical services, diagnostic services, surgical services, outpatient services, ancillary services, and related healthcare services that may be provided to me at Hoag Orthopedic Institute (HOI). These services may include, but are not limited to, physical examinations, laboratory testing, pathology testing, imaging studies, x-rays, ultrasound, medications, blood draws, intravenous therapy, anesthesia-related services, medical treatment, surgical treatment, respiratory therapy, rehabilitation services, nursing services, screening tests required or permitted by law, and other services ordered or provided by physicians, advanced practice providers, nurses, or other healthcare professionals involved. To assist in my care, I consent to evaluation and examination by a physician or other healthcare providers who may be physically distant from me via telehealth technologies, including but not limited to two-way video, digital images, and other telehealth technologies as determined by my providers. I also consent to my admission to the Hospital if this is necessary for my care. I understand that my care may be furnished under the general or specific instructions of my treating physicians or other licensed healthcare professionals. I also consent to my admission to the hospital, transfer between units or levels of care, placement in observation status, outpatient treatment, emergency treatment, or discharge when determined medically appropriate by my treating practitioners and HOI, consistent with applicable law and HOI policy. I understand that the practice of medicine and surgery is not an exact science and that no guarantee or assurance has been made regarding the outcome or result of any examination, treatment, procedure, service, or care.

2. HOSPITAL AND NURSING CARE

I understand that I am under the care and supervision of my treating physician or other licensed healthcare professional. HOI and its nursing staff are responsible for carrying out orders and instructions issued by my treating practitioners and for providing nursing and hospital services consistent with applicable standards of care, HOI policy, and applicable law. HOI provides general duty nursing services and nursing services ordered by my treating practitioners. HOI does not provide private duty nursing services unless separately arranged and approved in accordance with HOI policy. Patients or families who desire private duty nursing services are responsible for making independent arrangements for such services, subject to HOI's safety, credentialing, access, and operational requirements. Nothing in this section limits any right or obligation under applicable federal or California law.

3. LEGAL RELATIONSHIP BETWEEN HOAG ORTHOPEDIC INSTITUTE AND PHYSICIANS

I understand that all physicians who provide professional services at HOI are independent practitioners and are not employees, representatives, or agents of HOI. Independent practitioners may include, but are not limited to, anesthesiologists, radiologists, pathologists, hospitalists, intensivists, surgeons, consulting physicians, physician assistants, and other licensed professionals. Independent practitioners exercise independent professional judgment in the care they provide. HOI does not control the independent medical judgment of such practitioners. Professional fees for physician and practitioner services may be billed separately from HOI's hospital charges which means I may receive more than one bill for services.

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I understand that I am under the care and supervision of my physician(s). HOI and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, in medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

4. PERSONAL BELONGINGS AND VALUABLES

HOI asks patients and families **not** to bring money, jewelry, documents, cell phones, electronic devices, medications, assistive devices not needed for care, or other valuables that are not placed in the fireproof safe maintained by Hoag Memorial Hospital Presbyterian. HOI is not liable for the loss or damage to personal property, money, jewelry, documents, cell phones, electronic devices, or other items unless such items are deposited with HOI for safekeeping in accordance with HOI policy. HOI is not responsible for items left at the bedside, in patient rooms, in waiting areas, or otherwise retained by the patient, family, visitor, or representative when HOI staff have not taken possession of the items. The liability for loss of personal property deposited with HOI for safekeeping shall be limited to the amount permitted by applicable California law and HOI policy and shall not exceed $500 unless a greater amount is required by law.

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5. PARTICIPATION IN MEDICAL EDUCATION AND CLINICAL TRAINING PROGRAMS

I understand that HOI participates in teaching programs and that licensed physician fellows, students of health care professions (such as nursing, radiology, rehabilitation therapy, etc.), post-graduate students and other trainees may observe, examine, treat, and participate in my care and treatment under appropriate supervision as required by their medical education and clinical training programs.

6. PHOTOGRAPHS, VIDEOS AND RECORDINGS, IMAGES, AND CLINICAL DOCUMENTATION

I consent to HOI taking of photographs, videos, audio recordings, digital images, diagnostic images, procedure images, wound images, or other recordings or images of my medical condition, treatment, procedures, or care when used for treatment, patient safety, identification, documentation, diagnosis, quality improvement, peer review, risk management, compliance, education, training, healthcare operations, or other purposes permitted by law and HOI policy. I understand that any disclosure of identifiable images or recordings for purposes requiring separate authorization will occur only with separate written authorization when required by law. To protect patient privacy, safety, security, confidentiality, and the rights of HOI workforce members, medical staff, patients, visitors, contractors, students, volunteers, and others, HOI may impose reasonable restrictions on photography, filming, audio recording, video recording, livestreaming, or disclosure of images, recordings, or communications within HOI facilities.

Requests to record as a disability-related accommodation or as an auxiliary aid for effective communication will be reviewed on an individualized basis consistent with applicable law.

I understand that I and my visitors may not photograph, film, record, livestream, publish, or disclose images, recordings, or communications involving patients, visitors, workforce members, physicians, practitioners, students, volunteers, or others in HOI facilities except as permitted by HOI policy and applicable law.

7. FINANCIAL AGREEMENT

In consideration of all services provided by HOI I agree, whether I sign as patient or the patient's agent, spouse, parent, guardian or financial guarantor, that I will promptly pay the account of HOI in accordance with the regular rates and terms of HOI, including its charity care and discount payment policies, if applicable. I understand that all physicians and surgeons, including radiologists, pathologists, anesthesiologists, hospitalists, intensivists, consulting physicians, physician assistants, and other independent practitioners, will bill separately for their services. To the extent permitted by applicable state and federal law (after any attorneys' fees, collection expenses), should any account be referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
The regular rates of HOI, known as the "Chargemaster" and billing information are posted online at https://www.hoagorthopedicinstitute.com/for-patients/billing-and-insurance/ . The regular rates apply to services rendered by HOI, including services not covered by Medicare, or Medi-Cal or Medicaid, or not subject to other contractual arrangements.

PATIENT LABEL

Medical Debt: A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Initial Here: _____

8. FINANCIAL ASSISTANCE

Patients may be eligible for free or discounted care under HOI's Financial Assistance Program regardless of insurance status. Eligibility for financial assistance will be determined separately from these Conditions of Admission. I agree and understand, if I am unable to meet my financial obligation, I can contact the Financial Counselors by calling (949)764-5564 or by e-mail at FC@hoag.org. HOI can assist with your application and provide the applications for Medicare, Healthy Families Program, Medi-Cal, or other coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage. If you need further assistance understanding the billing and payment process, you may visit the Health Consumer Alliance website at https://healthconsumer.org to find referrals for organizations that may further assist you. You may also be referred to www.OCGOV.com for local assistance. We are committed to making information about the HOI Financial Assistance Program available in the communities we serve in a manner that is easy to understand. In addition to English, this summary, the HOI Financial Assistance Policy, and the HOI Financial Assistance Application form are available in other languages, including Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese. See our website at https://www.hoagorthopedicinstitute.com/for-patients/billing-and-insurance/financial-assistance/. HOI's determination of eligibility for financial assistance is separate from these Conditions of Admission and will be handled in accordance with HOI policy and applicable law. Access to medically necessary care will not be affected by whether financial assistance eligibility has been determined.

9. NOTICE OF PHYSICIAN FINANCIAL INTEREST

I acknowledge that I have been advised that HOI meets the definition of a "physician owned hospital" as defined by federal law (42 C.F.R. 489.3), and that a list of HOI's owners/investors, who are physicians or immediate family members of physicians, is available upon request and at https://www.hoagorthopedicinstitute.com/for-patients/legal-policies/legal-and-compliance. The undersigned acknowledges receipt of the *Hospital's Disclosure of Ownership* notice and understands that the patient has the option to choose a facility other than HOI for services requested or ordered by patient's physician.

Initial Here: _____

10. ASSIGNMENT OF ALL RIGHTS AND BENEFITS

Whether I sign as a patient or agent, I irrevocably assign and transfer to HOI all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to HOI for all insurance and health plan benefits payable for this hospitalization or for the outpatient services. I agree that the insurer or plan's payment to HOI pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by HOI to perfect, confirm or validate this assignment.

PATIENT LABEL

11. HEALTH PLAN (INSURANCE) OBLIGATION

HOI maintains a list of health plans with which it contracts. A list of these plans is available upon request from the Admitting and Registration Office or on our website at https://www.hoagorthopedicinstitute.com/for-patients/billing-and-insurance/insurances-accepted/ . HOI has no contract, express or implied, with any plan that does not appear on the list. It is my responsibility to determine that my health plan has authorized the services to be provided by HOI. Whether I sign as patient or agent, I agree that I am individually obligated to pay the account of HOI in accordance with the regular rate and terms of HOI including its financial assistance policies, if I belong to a plan which does not appear on the above-mentioned list or if I fail to obtain the health plan's authorization. Nothing in this section limits any protections available under the No Surprises Act, California law, Medicare, Medi-Cal, Medicaid, health plan law, emergency services law, or other applicable law.

All physicians and surgeons, including radiologists, pathologists, anesthesiologists, hospitalists, intensivists, physician assistants, and others, will bill separately for their services. It is my responsibility to determine if physicians providing services to me contract with my health plan, if any.

12. ACKNOWLEDGMENTS

a. I acknowledge that I have received the *Patient Information* brochure which addresses *Patient Rights* and how to file a grievance, *Patient Responsibilities*, and *Your Right to Make Decisions about Medical Treatment* (Advance Health Care Directive information) among other information.

b. I acknowledge and understand that from time to time, HOI may provide services to its hospital patients through the use of outside resources or under arrangements with third parties, including, for example, services provided to HOI patients by specialty reference laboratories or Hoag Memorial Hospital Presbyterian. In these circumstances, HOI retains professional and administrative responsibility for all services provided to its HOI patients by these outside resources.

13. LAB TEST ACKNOWLEDGEMENT: I hereby request and agree that my laboratory test results may be provided to the Patient Portal, so that I may access them electronically as part of my clinical health record. I understand that the laboratory test results made available through the Patient Portal may not include test results for a positive HIV test, hepatitis, drug abuse, or test results related to routinely processed tissues, or imaging scans that reveal a new or recurrent malignancy.

14. CALIFORNIA IMMUNIZATION REGISTRY

HOI may share your immunization or tuberculosis (TB) screening test records with the California Immunization Registry (CAIR), a statewide, secure and confidential database of patient immunization information. The CAIR is used by health care professionals, agencies, and schools to keep track of all shots and TB tests you take and can provide proof about immunization needed to start child care, school, or a new job. If you do not want your immunization or TB records to be shared with other registry users, please fax or email the *Decline to Share or Start Sharing Immunization Information Request (Lock/Unlock)* forms available on the CAIR website at http://cairweb.org/cair-forms/, to the CAIR Help Desk fax at 1-888-436-8320 or CAIRHelpDesk@cdph.ca.gov. CAIR may be contacted by phone at 1-800-578-7889.

15. TELEPHONE, MOBILE PHONE, PATIENT PORTAL ACCOUNT, AND E-MAIL COMMUNICATION

By providing us with a telephone number, mobile number, e-mail address, or other contact information, you agree that, in order for us or our service providers to service your account(s) (including contacting you about obtaining potential financial assistance for your account(s), appointment reminders, surveys, discharge instructions, and other health care notifications), or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you which could result in charges to you. You expressly consent that methods of contact may include using live agents, e-mail, pre-recorded and artificial voice messages, the use of an automatic dialing device, and/or text messages, as applicable. This consent applies to all services and billing associated with your account number(s) and is not a condition of purchasing property, goods, or services.

PATIENT LABEL

16. PROHIBITED ITEMS

a. HOI has a zero tolerance for violence in our facilities. As such, HOI is committed to maintaining a safe workplace that is free from threats and acts of intimidation and violence. For the safety and security of our patients, visitors, employees and other healthcare professionals, weapons, knives, alcohol, illegal drugs, and other dangerous materials are not allowed in our facilities. Marijuana is illegal under Federal law. HOI is a federally funded hospital, and marijuana is not allowed on hospital premises for storage or use, with the sole exception as outlined in California's Compassionate Access to Medical Cannabis Act for terminally ill in-patients. This Act allows for the use of medicinal cannabis within certain areas of the hospital for terminally ill patients who are admitted to our hospital, under certain restrictions.

b. Smoking, vaping, and the use of tobacco products (including chewing tobacco and electronic cigarettes) by all persons is prohibited anywhere within and on the grounds of any HOI or Hoag-owned, leased, or operated facility including in cars parked at any facility.

c. HOI reserves the right to inspect any item brought into the facility for safety purposes and may prohibit items deemed unsafe or inappropriate.

17. PATIENT AND VISITOR BEHAVIOR/CONDUCT

Patients and visitors are expected to conduct themselves in a respectful, non-threatening, non-violent, and non-abusive manner that promotes a safe environment of care. Threats, intimidation, violence, harassment, abusive behavior, unsafe conduct, interference with patient care, unauthorized removal of HOI property, or violation of HOI safety or security policies may result in appropriate action by HOI consistent with applicable law, patient safety obligations, EMTALA where applicable, CMS Conditions of Participation, licensing requirements, and HOI policy. Nothing in this section authorizes denial of emergency screening, stabilizing treatment, medically necessary care, grievance rights, nondiscrimination rights, or other rights protected by law.

18. ARTIFICIAL INTELLIGENCE

I agree and understand that HOI may utilize Artificial Intelligence (AI) technology, including generative AI, to assist healthcare providers and enhance and streamline documentation, communication, clinical support, and other healthcare operations. The utilization of AI may include, but is not limited to, transcription of medical notes and discussions, billing and coding support, clinical analysis and predictive health analytics. I understand that many professional medical services at Hoag are provided by independent physicians who are not employees or agents of HOI. Physicians are solely responsible for the medical care they provide, including any use of AI in their clinical decision-making or communications. To the extent required by law, some communications generated by AI will include clear notice that they were AI-generated and include instructions describing how to contact a human health care provider, employee, or other appropriate person.

By signing these Conditions of Admission, I acknowledge that I have been informed of the use of AI at HOI.

PATIENT LABEL

I certify that I have read these Conditions of Admission or have had them read or explained to me. I acknowledge that I have received a copy or have been offered a copy.

I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign and accept these Conditions of Admission.

Patient/Legal Representative Signature: _____ Date: _____Time: _____A.M./P.M.

If signed by other than the patient, indicate relationship: _____

Hospital Representative Name: _____

Hospital Representative Signature:_____ Date:_____Time:_____A.M./P.M.

Patient unable to sign.

Reason: _____

Witness Attestation: The undersigned hospital representative witnessed that the patient was unable to physically sign this document and there is no Authorized Legal Representative acting on behalf of the patient. The undersigned is not signing on behalf of the patient, is not acting as the patient's legal representative, and is not making a determination regarding the patient's decision-making capacity.

Hospital Representative Name and Title: _____

Hospital Representative Signature: _____ Date: _____ Time: _____A.M./P.M.

INTERPRETER'S STATEMENT

The foregoing document was translated by the interpreter (listed below) to the patient or legal representative in the patient's or legal representative's primary language (indicate language): _____
They understood all of the terms and conditions and acknowledged their agreement with the above document.
Interpreter services are provided free of charge to the patient.

☐ Interpreter Name and Identification Code: _____

☐ Offered Interpreter Service (free of charge); patient declined

☐ Family/Other interpreter used at patient's request - Interpreter Name and Relationship: _____

Witness: _____ Date: _____ Time: _____A.M./P.M.

PATIENT LABEL