HOAG ORTHOPEDIC INSTITUTE

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

CONDITIONS OF ADMISSION

The undersigned patient is admitted to Hoag Orthopedic Institute ("HOI" or "Hospital") for inpatient and/or outpatient treatment subject to the following terms and conditions:

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I consent to the procedures that may be performed during this hospitalization or on an outpatient basis. These may include, but are not limited to, laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services rendered to me under the general or special instructions of my physician or surgeon or other health care professionals assisting in my care, and screening tests or treatments required by law. 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.

2. HOSPITAL AND NURSING CARE

I understand that I am under the care and supervision of my physician(s),and that HOI and its nursing staff carry out the instructions of these physicians. I further understand that the HOI provides only general duty nursing care and care ordered by my physicians and that HOI is not responsible for failure to provide a private duty nurse. I hereby release HOI from any and all liability arising from the fact that HOI does not provide this additional care.

3. LEGAL RELATIONSHIP BETWEEN HOAG ORTHOPEDIC INSTITUTE AND PHYSICIANS

I understand that all physicians and surgeons furnishing services to me, including physician assistants, radiologists, pathologists, anesthesiologists, hospitalists, intensive care specialists, and other physicians are independent medical practitioners and are not employees, representatives, or agents of HOI. They have merely been granted the privilege of using the Hospital for the care and treatment of their patients. Fees for physician services are billed separately and independently from HOI charges which means I will receive more than one bill for services.

Initial Here: _____

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 personal belongings and valuable items into the facility. HOI is not liable for the loss or damage to any money, documents, jewelry, cell phones, electronic devices, or other items that are not placed in the fireproof safe maintained by Hoag Memorial Hospital Presbyterian. HOI is not liable for items left at the bedside at the discretion of the patient/family where staff do not take possession of the items. The liability for loss of any personal property deposited with HOI for safekeeping will be no more than $500.

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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.

PATIENT LABEL

6. PHOTOGRAPHS, VIDEOS, AND RECORDINGS

I consent to the taking of photographs, videos, or digital or other images (such as procedure images, wound photographs, etc.) of my medical or surgical condition or treatment, and the use of these images for purposes of my diagnosis or treatment or for HOI's operations, including peer review, quality improvement, education, or training. I understand that any disclosure or dissemination of photographs, videos, and digital or other images for other purposes is prohibited unless I provide my separate written consent.

I understand that neither I nor my visitors can photograph, film, record, or disclose or share any images or conversations of HOI employees, my physician(s), or others without the written consent of all parties involved.

7. FINANCIAL AGREEMENT

I agree, whether I sign as patient or the patient's agent, spouse, parent, guardian or financial guarantor, that in consideration of the services rendered, I agree to 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 physician assistants, radiologists, pathologists, anesthesiologists, hospitalists, intensive care specialists, and other physicians, will bill separately for their services. 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.

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

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/ .

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. 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: _____

PATIENT LABEL

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.

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/insurance/ . 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.

All physicians and surgeons, including physician assistances, radiologists, pathologists, anesthesiologists, hospitalists, 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.

c. I 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 professional medical services at HOI 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 this Conditions of Admission, I acknowledge that I have been informed of the use of AI at HOI.

PATIENT LABEL

13. 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 or Start Sharing/Immunization Information Request Form," 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.

14. TELEPHONE AND E-MAIL COMMUNICATION

By providing us with a telephone number or your e-mail address, 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.

15. 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.

16. BEHAVIOR/CONDUCT

It is the expectation of HOI that you conduct yourself in a respectful, non-violent and non-abusive manner. It is against Hospital policy for you to leave your assigned unit with property belonging to HOI (examples: gowns, IV pumps, oxygen tanks, monitoring devices, wheelchairs, etc.). You may be discharged if you leave the Hospital without informing your clinical team or if you violate HOI's policies.

PATIENT LABEL

I certify that I have read the Conditions of Admission and received a copy. I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign and accept its terms and conditions.

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

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

Hospital Representative: _____

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above.

Financially Responsible Party Signature: _____ Date: _____ Time: _____A.M./P.M.

Hospital Representative: _____

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 Service (free of charge) – Interpreter Name and Identification Code: _____

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

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

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

PATIENT LABEL