

CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

The undersigned or if a minor the parent(s) / person having legal custody / legal guardian, consents to the procedures that may be performed during this hospitalization or on an outpatient basis. These may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or surgical treatment or procedures, telehealth services, anesthesia, or hospital services provided to the patient under the general and special instructions of the patient's physician or surgeon. The undersigned or legal representative understands that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. The undersigned of legal representative acknowledges that no guarantees have been made regarding the result of examination or treatment in the health care agency. For minors this authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and Section 1283 of the Health and Safety Code of California.

NURSING CARE WITHIN THE HOSPITAL

This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the services of a special duty nurse, it is agreed that such must be arranged by the patient or his/her legal representative, unless special arrangements are made, the hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care.

LEGAL RELATIONSHIP BETWEEN FACILITY AND PHYSICIAN

Except as provided in the following paragraph, all patients admitted to the Ventura county Medical Center (VCMC) or Santa Paula Hospital (SPH) are under the care and supervision of the hospital's 'in-house' physicians, which may include resident physicians, contracted specialists, clinical coordinators and consultants, as well as radiologists, pathologists, and anesthesiologists. All patients on an outpatient or inpatient basis consents to x-ray examinations, laboratory procedures, anesthesia, medical or surgical treatment, or hospital services rendered to him/her under the general and special instructions of the physician responsible for his/her care. The undersigned recognized that all physicians who admit and treat their private patients and VCMA/SPH do so as independent physicians and are not employees of agents of VCMS/SPH.

PERSONAL VALUABLES AT VCMC/SPH

As a patient, I am encouraged to leave personal items at home. The hospital maintains a fireproof safe for the safekeeping of money and valuables. The hospital is not liable for the loss or damage to any money, jewelry, documents, or other articles that are not placed in the safe. Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars (\$500) unless I receive a written receipt for a greater amount from the hospital.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the (1) hospital charges in accordance with the regular rates and terms of the hospital and (2) professional charges for physician and surgeon services provided to the patient, such as emergency room physician, radiologist, pathologist, anesthesiologist, surgical and similar specialty which are billed separately from hospital charges. Should the account be referred to a collection agency or to an attorney for collection, the undersigned shall pay reasonable fees, including attorney's fees and collection expenses.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes, whether he/she signs as agent or patient, direct payment to the hospital of any insurance benefits otherwise payable to the undersigned for this hospitalization at a rate not to exceed the hospital's regular charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

HEALTH CARE SERVICE PLAN OBLIGATION

The undersigned agrees that he/she is individually obligated to pay the cost of all services rendered beyond those reimbursed to the hospital by the patient's health care services plan, unless such service plan has a contract with the hospital which relieves the undersigned of payment responsibility for covered services. The undersigned assumes full responsibility for all charges not covered by such plan and for any co-payment or deductible required by such plan. Medicare regulations require that we inform you, your hospitalization is subject to medical review by a federally contracted peer review organization. In the event that your hospitalization does not meet the Medicare guidelines, you will be notified.

PATIENT'S RIGHTS & RESPONSIBILITIES/NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION/ AN IMPORTANT MESSAGE FROM MEDICARE/ ADVANCE DIRECTIVES/ SPIRITUAL NEEDS

I have been informed that all of the above notices/information is contained in the "Patient Information Booklet." I have been provided the Patient Information Booklet. I also understand this facility posts a brief Summary and the Privacy Practices and my Right and Responsibilities in several prominent locations for my convenience.

DO YOU HAVE AN ADVANCED DIRECTIVE?

No- Would you like more information or assistance with advanced directives? No Yes, If yes _____

Yes-

Placed in current chart.

Previously provided to VCMC and patient does not have a copy: Notify Medical Records to locate advance directives and place in the chart by faxing this form to Medical Records at 805-652-5998.

Date and Time Faxed: _____

UNABLE TO ASSESS DUE TO PATIENT CONDITION-

Family unavailable

Or

Family is unaware of patient's advanced directive status

Signature: _____ Date: _____ Time: _____

Relationship to patient: _____

IF PATIENT IS UNABLE TO SIGN:

State Reason: _____

Witness Signature: _____

Witness Print: _____

Witness Title: _____