Patient Name:___________________ Date of Birth:__/____/____ Current Date: __________

Parkway Surgery Center (PSC): Condition of Admission

1. **MEDICAL AND SURGICAL CONSENT**: I, the undersigned, consent to the services which may be performed during this outpatient visit including emergency treatment or services, which may include but are not limited to medical, surgical treatment , anesthesia, pathology, emergency procedures, laboratory procedures, diagnostic procedures, rendered to me under the general and special instructions of my physician. This consent includes testing for blood-borne infectious diseases, including but not limited to Hepatitis, Acquired Immune Deficiency Syndrome (AIDS),and Human Immunodeficiency Virus (HIV), if a physician orders such tests for diagnostic purposes. If the patient takes any medications or other substances without orders from the physician, the patient hereby releases the PSC and physician from liability for any reaction that may occur. In the event of an emergency, **I authorize Parkway Surgery Center to transfer myself to another health care facility should my physician determine if necessary. In addition, I also consent to the release of my medical records to such facility.**
2. **RELEASE OF INFORMATION:** I authorize the PSC and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during the outpatient visit to any organization which is or may be liable or responsible for payment of charges associated with my care. If my injury is work-related, I authorize the clinic to release any information from my medical records to my employer and/or its designee. I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses, technicians at the hospital, home health agencies, ambulance companies, and such other health care agencies involved in my care. I acknowledge that patient medical records at the clinic are made available through computer networks to hospital personnel, physicians involved in my care and their offices.
3. **PATIENT PRIVACY:** I have read and/or received the information sheet entitled:
   "HIPAA NOTICE OF PRIVACY PRACTICES" available to me at www.mountainviewhospital.org
   ❑ YES, I have received and/or had the opportunity to review MVH's "Notice of Privacy Practices" either in electronic or paper form. Any questions that I had were answered.

   ❑ NO, I did not receive nor have had the opportunity to review MVH's "Notice of Privacy Practices"

4. **PATIENT RIGHTS:** I understand that Parkway Surgery Center has adopted an extensive Patients' Rights policy, which affords patients' rights to respect and foster the patient's dignity, autonomy, positive self-regard, civil rights and involvement in their case. These rights are posted in PSC and available on MVH website or by asking the admissions clerk for a copy of the Patient's Rights Pamphlet. Complaints regarding PSC may be filed with the Bureau of Facility Standards, P.O. Box 83720 Boise, Id. 83720, Phone 208-334-6626 Option 5, Fax 208-364-1888, e-mail fsb@dhw.idaho.gov . Medicare beneficiaries, the website for Office of the Medicare Ombudsman http://www.medicare.gov/ombudsman/resources.asp

5. **WEAPONS/EXPLOSIVES/DRUGS:** I understand and agree that if the PSC at any time believes there may be a weapon, explosive device, or illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the PSC may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.
6. **FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS:** In consideration of PSC services rendered, I hereby authorize payment directly to the above named PSC for benefits otherwise payable to me, but not to exceed the PSC regular charges. In addition, I authorize payment of Medicare/Medicaid/insurance benefits to any contracted provider, this

includes, but is not limited to laboratory procedures, radiology procedures, and anesthesia, pathology, or hospital services rendered to me under the general and specific instructions of my physician during this encounter. I understand that I am financially responsible for charges not covered by my plan. In the event that this account is not paid according to the terms of the clinic's credit policy, I agree to pay interest at the rate of 18% APR and/or costs of collection, not to exceed reasonable legal fees and court costs. If my account is assigned to a collection agency for collection and suit is filed to recover payment I agree to pay a reasonable attorney's fees, 33% of the principal and interest on my account balance, or any sums awarded by the court, whichever is greater, I further agree to pay reasonable costs of suit.

7. **MEDICARE PATIENT CERTIFICATION:** I certify that the information given by me in applying for payment under Title XVII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries, or carriers any information needed for this or related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.
8. **MOUNTAIN VIEW HOSPITAL IS A PHYSICIAN OWNED HOSPITAL:** Upon request a List of Ownership will be provided to you.
9. **ADVANCED DIRECTIVES:** I acknowledge that I have been given information regarding Idaho State Law on living wills and advanced directives. Advanced Directives are documents such as living wills, durable power of attorney, or health care surrogate appointments.

Please mark box if patient obtains any below:

- ❑ I have a "Durable Power of Attorney for Health Care Services at this time"
- ❑ I have a "Living Will at this time"
- ❑ I possess a signed donor card.

I hereby certify and state that I have read, and that I fully and completely understand the Conditions of Admission and authorization for medical treatment, and that I have signed the Conditions of Admission knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurance, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

❑ ***Please check box if patient is medically unable to sign this Conditions of Admission***

______________________________ ______________________________

Patient/Parent/Guardian/Conservator: If other than patient, indicate relationship:

______________________________ ______________________________

Date & Time: Witness: