Rady Children's Hospital San Diego
3020 Children's Way
San Diego, CA 92123

PLACE PATIENT
ID LABEL INSIDE BOX

DT70320-A

Conditions of Treatment / Admission

This Agreement contains the conditions of admission and treatment of patients at Rady Children's Hospital - San Diego (the "Hospital"). The patient, the patient's legal representative, or an individual duly authorized by the patient as the patient's legal representative, is asked to read and sign this Agreement, to ensure that the Hospital and physicians treating patients at the Hospital may provide health care to their patients, and patients may receive care in an atmosphere where patients and their families and representatives clearly understand their rights and obligations. This Agreement is a legally binding contract between you (the undersigned) and the Hospital. Please ask any questions before signing this Agreement.

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES.** The undersigned consents to the treatment and procedures which may be performed during hospitalization(s) and any outpatient visit(s), including but not limited to, ambulatory visits, emergency or urgent care services, laboratory imaging, x-ray examinations, drawing blood for tests, medications, injections, and other diagnostic services, nursing care, medical and surgical treatment and procedures, anesthesia, or other Hospital services rendered to me, under the general and specific instructions of the patient's physician or surgeon. It is the policy of the Hospital that no patient should die or suffer serious injury as a result of withholding blood or blood products in a medical emergency. Therefore, blood will be administered to minor children with or without the consent of the parent or legal guardian. I also consent to my admission to Rady Children's Hospital - San Diego, if this is necessary for my care. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in the Hospital.
2. **NURSING CARE.** The Hospital provides only general nursing care and care ordered by the physician(s), unless the patient's physician orders more intensive nursing care. Should the patient desire to hire a private duty nurse, the Hospital assumes no responsibility for the acts or omissions of these nurses. The Hospital is not responsible for failure to provide a private duty nurse, and is hereby released from any and all liability arising from the fact that the Hospital does not provide this additional care.
3. **TEACHING PROGRAMS.** The Hospital is a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, x-ray, rehabilitation therapy), post-graduate fellows, and other trainees may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of the Hospital's medical and clinical education programs. These faculty members may not have a California license, but may be licensed in another state or country. Some physician faculty members are permitted to practice medicine in California under a special program developed by the Medical Board of California.

   I also understand that one of the Hospital's institutional review boards approves research projects conducted by Hospital researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.
4. **PHYSICIANS AND HOSPITAL – PATIENT'S SEPARATE FINANCIAL OBLIGATIONS:** The physicians and surgeons furnishing services to the patient, including but not limited to radiologists, pathologists and anesthesiologists, are independent contractors and ***are not employees or agents of the Hospital***. When required, they will obtain the patient's informed consent to medical or surgical treatment, special diagnostic and therapeutic procedures or Hospital services rendered to the patient under the general and special instructions of the physician.

   The patient will be billed separately by the physicians and surgeons for their services provided during hospitalization. It is the patient's responsibility to pay or arrange payment of those bills and to determine whether there are any health care benefits available for that purpose.

   The patient will be billed separately by the Hospital for hospital and nursing services provided during hospitalization. It is the patient's responsibility to pay or arrange payment of all accounts for Hospital services before discharge or release and to determine whether there are any health care benefits available for that purpose. The Hospital maintains a list of health benefit plans that contract with the Hospital to cover health care costs. The list is available from the Hospital's Financial Counseling Office. The Hospital reserves the right to terminate contractual agreements with health benefit plans without express written notice to the patient. Hospital charges will be in accordance with the Hospital's regular rates and terms. The legal rate of interest may be assessed on the unpaid balance of any Hospital account owed by the patient beginning the sixtieth (60) day after the account becomes due and payable. In the event that the account is referred to a collection agency or an attorney for collection, the financially responsible party shall pay reasonable costs of collection, including, without limitation, attorneys' fees and court costs.
5. **PERSONAL VALUABLES.** It is recommended that no valuables are brought into the Hospital. The Hospital is not responsible for the loss of or damage to any property or valuables brought into the Hospital by a patient or by a patient's visitor.
6. **ASSIGNMENT OF HEALTH INSURANCE BENEFITS.** In consideration of the health care services provided (the "Services"), the undersigned, whether signing as a patient or legal guardian:

   1. irrevocably (without the right to revoke) and expressly assigns and transfers to Hospital all of my rights, benefits, privileges, protections, claims and any other interest of any kind arising out of, relating to or concerning the provision of Services by Provider (collectively, "Rights"). "Provider" includes, without limitation, Hospital, all physicians and care providers, and all other persons or entities on whose behalf Hospital provides billing services in connection with the Services. My assigned Rights include, without limitation, rights to all benefits due under a health insurance contract or policy relating to the Services, payment, appeal rights, rights to sue, rights to penalties available by contract or law, fees and interest, rights to obtain copies of plan documents and materials, rights to request the disclosure of documents and materials relating to a bill submitted on my behalf, rights to seek any and all appropriate equitable relief (fair remedy) in the event that my health benefit plan or health plan representative fails to deliver any of the benefits agreed upon under my contracted plan, rights to pursue claims of any nature, and rights to seek attorney fees and/or fees of any kind available by contract or law, that I had, have or may have in the future against anyone, including without limitation an insurance plan, health benefit plan, private or group health/

CONTINUED ON THE REVERSE SIDE

hospitalization plan, self-funded plan, and any third party payor, fund, or any source of payment, insurance, indemnity or health/medical coverage of any kind (collectively "Coverage Source").

2. designates Provider as my authorized representative, to act on my behalf, in connection with all matters arising from or relating to Rights and Coverage Source. Should direct payment from a Coverage Source not cover all charges, it is understood by the undersigned that he/she may be financially responsible for any remaining balance. Where Services result from a liability payable directly to the insured from my health benefit plan and/or a third party liability policy(ies), either by contractual obligation or legal action, the undersigned, to the extent my account remains unpaid or underpaid by an amount that is less than the full billed charges, agree (a) not to settle such action without Provider's written consent (b) will notify Provider of this potential right to payment; and (c) do hereby grant Provider a lien (a legal right that attaches), effective immediately, on any such proceeds received or due to me or my representative, whether through settlement or judgment, up to the full billed charges, unless written authorization to the contrary has been issued by Provider or its authorized representative.

7. **USE/DISCLOSURE OF INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS.** The undersigned understands that as part of providing healthcare, the Hospital originates and maintains health records describing health history, medications, allergies, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. Disclosures for purposes of treatment, payment and health care operations are described in our Joint Notice of Privacy Practices provided to you at the time of admission or your visit. The Hospital may further use or disclose patient identifiable medical information as required and permitted by federal and state laws and regulations.

   Please be aware that we may monitor and record incoming or outgoing telephone calls within the Automatic Call Distribution System for quality assurance purposes. Such calls will include a recorded or live message that the call is being monitored or recorded.

   I hereby consent to receive live, artificial, autodialed or pre-recorded calls from Rady Children's, its providers or its agents, including HRMG, CBB, PMS, CMRE, ACE, CRB, PFS group, and any other debt collectors, for any permissible purpose, including debt collection. I understand that my consent is not a condition for obtaining treatment, or making purchases.

8. **RESPONSE TO EXTERNAL INQUIRIES.** The Hospital may include certain limited information about the patient in the Hospital directory. This information includes patient name, location in the hospital, patient's general condition and patient's religion affiliation. The directory information, except for the patient's religious affiliation, may be released to anyone, including the media, who asks for the patient by name. The patient may opt out of the Hospital Directory and become a "confidential" patient type. Unless you specifically refuse to have this information in our directory, this information will be used to allow visitors to find your/your child's room, to allow florists to deliver flowers to the patient or to respond to questions about the patient's general condition.

   By initialing here, I Decline to have the patient listed in the Hospital Directory (OPT-OUT) Please initial inside the box: ☐

   In addition to declining to have the patient listed in the Hospital Directory, you have the option to designate the patient as a "No Information" patient type. This restriction on a patient's medical record indicates that RCHSD will not acknowledge the patient's presence in the hospital or even in our medical record system at all over the phone including to the parents, caregivers, and legal guardians that may be listed as contacts in the patient's medical record. This restriction will prohibit you/parent/guardian from being able to reschedule or confirm appointments over the telephone. Do you want to prohibit RCHSD (including its affiliate providers) from providing any information over the telephone related to patient's care or that could be used to confirm the patient is in our medical system?

   By initialing here, I Decline to have any patient information released over the telephone even to a legal guardian, parent or authorized caregiver (OPT-OUT) Please initial inside the box: ☐

9. **COMMUNITY SERVICE OBLIGATION.** The facility is prohibited by law from discriminating against patients covered by Medi-Cal and certain other state and federally funded programs. Should the patient believe he/she may be eligible for Medi-Cal or other state and federally funded programs, the patient may contact our Financial Counseling Office for assistance in applying for coverage.

10. **ADVANCE DIRECTIVES.** An adult patient and certain minor patients with capacity may execute an Advance Directive for Health Care. This includes: Adults (age 18 or over), self-ufficient minors, married or previously married minors, emancipated minors or minors in the Armed Forces.

    Does the patient have a current Advance Directive for Health Care? ☐ **Yes** ☐ **No**

    If yes, copy provided for the chart. **Please initial inside the box.** ☐

    If not available, name the advance directive agent and contact information.

    Advance Directive Name:_____ Phone#:_____

    The brochure, **"Your Right to Make Decisions About Medical Treatment"**, has been received at this admission.

    Please initial inside the box. ☐ Do you wish to execute an Advance Directive at this time? ☐ **Yes** ☐ **No**

11. **CAR SEAT.** California law requires that all Hospitals, clinics and birthing centers must provide information about the requirement for child passenger restraint systems, to parents or legal guardians before children are released from the Hospital. By signing below, it is acknowledged that the Hospital has provided the undersigned with information and discussed the legal requirements pertaining to the use of a child restraint system.

    My signature below means that ***I have given truthful information about this child's name and identity***. It also means that ***I Understand***:

    - How important it is to provide truthful and accurate information about my child's/this child's name and identity.
    - That incorrect or false information about identity can lead to treatment that could harm this child.
    - That Rady Children's Hospital - San Diego reserves the right to take action for intentional presentation of false information including transfer of care and appropriate reporting to authorities.

    The undersigned certifies that he/she read this entire Agreement, received a copy of this Agreement, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms on his/her behalf.

DATE	TIME	PATIENT / RELATIVE / GUARDIAN / CONSERVATOR	RELATIONSHIP IF NOT PATIENT	WITNESS