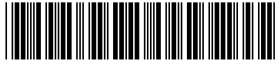
Rady Children's

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

PLACE PATIENT
ID LABEL INSIDE BOX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Conditions of
Treatment / Admission

CONDITIONS OF TREATMENT / ADMISSION

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES.** The undersigned patient or patient's legal representative 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, telehealth, emergency or urgent care services, laboratory procedures, imaging procedures, other diagnostic services, nursing care, medical and surgical treatment and procedures including medications, anesthesia, or other hospital services rendered to the patient, under the general and specific direction of the patient's physician.

   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 minors with or without the consent of the parent or legal guardian. I understand that the practice of medicine and surgery is not an exact science, that unpreventable complications may occur, and that diagnosis and treatment may involve risks of injury or death. 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 with staffing provided by, and levels determined by, management, and other care prescribed by the physician(s). Private duty nursing is not provided.

3. **TEACHING PROGRAMS.** The hospital is a teaching, research and healthcare institution. Medical students and post-graduate trainees may observe, examine, treat, and participate in other aspects of care at the direction, and under the supervision, of the patient's attending physician or other physician designee. In addition, students of other health and human services professions, including but not limited to nursing, social work and developmental/rehabilitative services may participate in the patients care under the supervision of licensed staff.

   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 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 the patient's ability to obtain medical care.

4. **LEGAL RELATIONSHIP BETWEEN PHYSICIANS AND HOSPITAL.** Physicians furnishing services to the patient, including but not limited to attending physicians, hospitalists, radiologists, pathologists and anesthesiologists, are independent contractors and ***are not employees, representatives, or agents of the hospital and exercise independent medical judgement in the care and treatment of patients.*** Your physician is responsible for obtaining informed consent for certain aspects of medical-surgical care in which such consent is required.

5. **PATIENTS FINANCIAL AGREEMENT.** I agree to promptly pay all hospital bills in accordance with the charges listed in the hospital's charge description master and, if applicable, the hospital's charity care and discount payment policies and state and federal law. I understand that I may review the hospital's charge description master before (or after) I received services from the hospital.

   The patient will be billed separately by physicians 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 services provided during hospitalization. It is the patient's responsibility to pay or arrange payment of all accounts for hospital services before discharge and to determine whether there are any health care benefits available for that purpose. The hospital contracts with a number of health benefit plans. The hospital reserves the right to terminate contractual agreements with health benefit plans without express written notice to the patient. Any questions regarding eligibility scope of coverage and reimbursement should be referred to your health plan or insurer.

   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.

6. **PERSONAL PROPERTY, INCLUDING VALUABLES.** It is recommended that no valuables be 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, including but not limited to, personal electronic devices such as cell phones and tablets.

7. **ASSIGNMENT OF ALL RIGHTS AND 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 assigns and transfers to hospital all rights, benefits, and any other interests in connection with any insurance/ health care service plan, health benefit plan, or other source of payment for the provision of care and services by provider. "Provider" includes, without limitation, hospital, all physicians and other care providers delivering services, and all other persons or entities on whose behalf hospital provides billing support in connection with the services. This assignment shall include, but not be limited to, assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer or plan's payment to the hospital 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, this hospital to perfect, confirm, or validate this assignment.

   2. designates provider as my authorized representative, to act on my behalf, in connection with all matters arising from or relating to rights and source of coverage, as referenced above. 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.

CONTINUED ON THE REVERSE SIDE

8. **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, encounters for health screening or diagnostic testing and treatment, and any plans for future care. 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.made to me regarding the result of examination or treatment in the hospital.

9. **NOTICE OF THE OPEN PAYMENTS PROGRAM.** The Open Payments program is a national disclosure program that promotes transparency and accountability by helping consumers understand the financial relationships between pharmaceutical, medical device industries and physicians and teaching hospitals. The Open Payments database is a federal tool that can be used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provide on this notice. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. Please visit the Open Payments site noted above for more information or speak to your provider if you have questions.

10. **COMMUNICATION.** 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.

    In order to service the account, or to collect any amounts owed, I hereby consent to receive artificial, autodialed, pre-recorded calls, or SMS text messages from Rady Children's, its providers or its agents, including but not limited to, HRMG, CBB, PMS, CMRE, OVAG, IPFS, Televox, and any other debt collectors, for any permissible purpose, including debt collection and appointment reminders, by telephone, including cell or mobile phone numbers, now and continuing on in the future. The number provided below, or any subsequent telephone number associated with my account, may be used for this purpose. I understand that my consent is not a condition for obtaining treatment or making purchases.

    Cell phone #: ______________________ ☐ **YES, I consent.** ☐ **NO, I do not consent.**

11. **RESPONSE TO EXTERNAL INQUIRIES.** The hospital maintains a Hospital Directory that is used during hospitalization(s) (an inpatient stay), which may include certain limited information about the patient. This information includes patient name, location in the hospital, patient's general condition and patient's religion affiliation, if any (which may be disclosed to clergy only). 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. This information will be used to allow visitors to find the patients room or to respond to a question about the patient's general condition. You may refuse to have this information in our directory and designate this specific hospital admission as a private encounter. If you elect to opt out of the facility directory we will not disclose that the patient is in the hospital to any outside callers or visitors that present to the hospital asking for the patient by name.

    By checking this box, I decline to have the patient listed in the Hospital Directory (OPT-OUT) ☐

12. **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.

13. **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-sufficient minors, married or previously married minors, emancipated minors or minors in the Armed Forces.
    If you have an Advance Directive, please provide a copy to staff. A standard form is available at:
    https://oag.ca.gov/sites/all/files/agweb/pdfs/consumers/ProbateCodeAdvancedHealthCareDirectiveForm-fillable.pdf

    For more information on Advance Directives: see https://oag.ca.gov/consumers/general/care

14. **CAR SEAT.** California law requires that all hospitals and clinics 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 patient's name and identity.*** It also means that ***I understand:***

    - How important it is to provide truthful and accurate information about this patient's name and identity.
    - That incorrect or false information about identity can lead to treatment that could harm this patient.
    - 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 to execute the above and accept its terms on his/her behalf. If signed by someone other than the patient, enter name and relationship.

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