# Admission Agreement

**Authorization for Medical Treatment:** OneCore Health and its Medical Staff are hereby authorized to administer any medical, diagnostic or therapeutic treatment, including blood transfusions, deemed necessary or advisable during this period of care. I have the right to consent, or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

**Release of Responsibility:** I have released OneCore Health from any responsibility for any items of personal property that I choose to keep with me. I have been informed, however that the Hospital does have a lockable cabinet in which I can deposit personal property for safekeeping. I understand the hospital will not be liable for any loss of my personal property.

**Release of Information:** I consent to OneCore Health and its Medical Staff to use my medical and billing information for treatment, payment and health care operations. I consent to release of all or part of my medical and billing information for this period of care to (1) any insurance carrier, worker's compensation carrier or self-insured employer group responsible for reviewing and/or paying any part of my hospital charges and (2) to any physician or health care provider involved in my continuum of care. **Information I consent for release may include information regarding non-communicable and communicable or venereal disease including, but not limited, to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Disease (AIDS).** This consent for disclosure may be revoked in writing at any time. Contact the Medical Records Department at OneCore Health (405-631-3085) for further information. This revocation cannot apply to information already released based on this consent or disclosures required by State and Federal laws. I understand the person of organization receiving this information could re-release it to others and federal law would no longer protect it. I release OneCore Health, its staff, employees, officers and directors from any responsibility for such re-release.

**Payment for Medical Care:** In consideration for the medical care I receive from the Hospital, it's employees, agents, designees, or independent contractors, I agree to make full payment of all charges to OneCore Health or by other providers of medical care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third party Payor.

**Assignment of Benefits:** I authorize and assign payment to OneCore Health of any type of reimbursement or any payment from Medicare or State Medicaid programs, or other third party Payors, for any and all costs of my medical care provided by the Hospital or by its agents, designees, or independent medical contractors.

**Insurance Pre-Certification:** I understand that pre-certification for my insurance coverage is my responsibility as the patient. I assume all responsibility for notifying my insurance company and obtaining approval.

**Notice of Privacy Practices:** I understand that I have the right to receive a notice of OneCore Health legal duties and privacy practices with respect to my medical and billing information. I have received a copy of this Notice of Privacy Practices.

**Patient Rights:** I acknowledge the information I have been given explaining my rights as a patient. I have also received a copy of the State Notice and OneCore Health's policy statement regarding Patient Rights to Self-Determination.

**Strictly No Report Status:**
I understand that being listed as a "Strictly No Report" patient means:

- Callers/Visitors asking for me by name will be told "OneCore Health does not show a patient by that name"
- I am responsible for informing family and others of my admission, room, and phone number
- Flowers without my room number will be returned to the florist
- Mail without my room number will be returned to the sender.

I can change my "No Report" status at any time by informing my nurse of my decision.

I wish to be listed as a Strictly No Report Patient: ❑Yes ❑No*

*If No, I consent to my release of medical information if my family/friends or other designated individuals provide the following password: ___________________________________________

**Advance Directive:** I acknowledge being provided information regarding my right to prepare an advanced directive:

| | |
|---|---|
| I have an Advance Directive: | ❑Yes ❑No |
| ↳ I have provided a copy of my Advanced Directive to OneCore Health. | ❑Yes ❑No |
| I do not have an Advanced Directive and would like more information. | ❑Yes ❑No |
| ↳ Packet Provided by Admission Representative: | ❑Yes ❑No |
| I have a designated Medical Durable Power of Attorney. | ❑Yes ❑No |
| I have a legal guardian. | ❑Yes ❑No |
| ↳ If yes, my legal guardian's name is: ____________________________ | |

**Ownership Disclosure Statement:** OneCore Health is a physician-owned facility and a list of physician owners is available upon request. Your physician may be an investor in the facility. Your physician receives no compensation from OneCore Health for referrals. Please advise us if you desire to be referred to another facility.

**Disclosure of Emergency Response:** A physician is usually on site during normal business hours. Our staff is prepared to respond to medical emergencies and on-call physicians are available anytime a physician is not in-house. On-call physicians are available at all times to directly communicate with staff providing patient care and respond to the patient's bedside for any emergent need.

**I have received a copy of the Patient's Rights and Responsibilities, the facility Privacy Notice, Patient's Right to Self-Determination and have answered the questions regarding an Advance Directive/Living Will.**

**I have received this Admission Agreement and fully understand its content and implications.**

________________________________________________________________________________

Signature of Patient, Parent, Legal Guardian, Representative Guardian | Date/Time | Please Print Name of Patient, Parent,

________________________________________________________________________________

Signature of Guarantor | Relationship to Patient | Date/Time | Please Print Name of Guarantor

________________________________________________________________________________

Signature of Witness | Date/Time | Please Print Name of Witness