Consent for Admissions: I request and consent to admission to the Hospital for Special Surgery

Consent to Medical Care: I request and consent to medical care and diagnostic procedures that my attending physician(s) or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in the Hospital for Special Surgery is under the direction of my attending physicians(s) and the hospital is not responsible for acts of omission of my attending physician(s).

Unborn Child Coverage: If pregnant, the above consent for treatment, releases, assignments, and guarantor agreement apply to my newborn child if born at this hospital during this period of treatment.

Teaching Programs: I understand that I may be seen and examined by supervised students and/or residents/fellows as a part of the educational program. I agree to participate in these programs, but reserve the right to limit my participation at any time.

Release of Information: I authorize the Hospital for Special Surgery to release any medical or financial information to a medical care provider who is performing medical care or a diagnostic test(s) on behalf of; or at the request of my attending physician, or his/her designees, of the Hospital. I authorize the Hospital, its agencies and designees, to utilize any information in my medical record for quality assurance and risk management activities. **By state law,** you must be advised that the information authorized for release may include records, which may indicate the presence of a communicable, or venereal disease, which include, but is not limited to, disease such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Symptoms (AIDS).

Advanced Directive, Organ/Tissue Donor, Patient Rights, and Privacy Notice: The patient, or his or her representative, hereby acknowledges having been provided with information regarding patient rights, advance directives, organ/tissue donation, and the facility privacy notice. The following documents have been executed.

Do you have an Advance Directive and/or Living Will?	☐ Yes	☐ No	☐ Copy on Chart	OR	☐ Waiver signed
Do you have a signed DNR Form?	☐ Yes	☐ No	☐ Copy on Chart		
Would like more information on Advance Directives?	☐ Yes	☐ No	☐ Information given		
Do you have a Medical Durable Power of Attorney?	☐ Yes	☐ No	☐ Copy on Chart		
Do you have a legal guardian?	☐ Yes	☐ No			

Please provide Name_____

Have you received a Copy of the Bill of Rights?	☐ Yes	☐ No	
Have you received a copy of the Notice of Physician Ownership?	☐ Yes	☐ No	
Have you received a copy of the Privacy Notice?	☐ Yes	☐ No	
Have you received a copy of the Flu/Pneumonia Vaccine Education Packet?	☐ Yes	☐ No	☐ NA

I do_____ do NOT_____ wish to be an organ or tissue donor. My family has _____ has NOT_____ been informed of my decision.

Personal Property: I have been informed and understand the Hospital does not assume any responsibility for personal property that I choose to keep with me. I have been informed, however, that the Hospital does have a safe in which I can deposit personal property for safekeeping. I have been informed and understand that the Hospital will not be liable for any loss of my personal property unless it is placed in the safe maintained by the Hospital.

Payment for Medical Care: I agree that in consideration for the medical care I receive from the Hospital, its employees, agents, designees, or independent contractors. I guarantee full payment for all changes by the Hospital for Special Surgery or by other providers of medical care, for such care, subject only to restrictions imposed by the Medicare or State Medicaid Programs, or by any third party payor (for example, an insurance carrier or health maintenance organization (HMC) with which Hospital has specifically entered into an agreement for payment of medical care provided by the Hospital or by its employees, agents, designees or independent contractors).

ASSIGNMENTS OF BENEFITS: I hereby authorize and assign payment to the Hospital of any type of reimbursement or payment from Medicare or State Medicaid programs or other third party payor, for any and all cost of my medical care provided at the Hospital or by its agents, designees, or independent medical contractors. Further, I understand that **Anesthesiology, Physician Services, Pathology** and some **Laboratory Services** will bill me separately and assign my insurance benefits to them if their services are rendered during my treatment. I also authorize them to release my medical information needed by my insurance carrier to process the claim

Insurance Precertification: I understand that precertification for my insurance is a patient responsibility. I assume all responsibility for notifying my insurance company and obtaining approval.

Release of Financial Information: I herby authorize the Hospital for Special Surgery, its employees, agents, designees, or independent contractor to disclose any and all information regarding the medical care I received on the admission to this Facility or through its employees, agents, and designees, or independent contractors to any third party payor responsible for paying the costs of my medical care and any part thereof.

I have reviewed this Admission Agreement and fully understand its contents and implications.

Signature of Patient, Parent, Legal Guardian, Representative		Date/Time	Please Print Name of Patient, Parent, Guardian
Signature of Guarantor	Relationship to Patient	Date/Time	Please Print Name of Guarantor
Signature of Witness		Date/Time	Please Print Name of Witness

If Legal Guardian or Other Legal Representative for the Patient, please provide your age and relationship to the patient, and the reason why the Patient is incompetent or unable to sign. If an emancipated minor, please state whether you have lawfully married or a parent or legal guardian of a child.

ONECORE HEALTH ORTHOPEDIC HOSPITAL

ADMISSION AGREEMENT .

Place Patient Sticker Here

Revised 1/2009, 10/10, 4/14