Conditions of Admission
McGehee Hospital & McGehee Family Clinic

CONSENT: I hereby authorize McGehee Hospital ("Hospital") and my physician, any attending physician, or the emergency department physician to render any necessary hospital care, including surgical operations, diagnostic procedures, medication management, drugs, supplies and emergency treatment, that the physician, his assistants and designees and employees of the Hospital deem necessary or advisable in their judgment. I authorize the Hospital to dispose of any tissues removed in the performance of any procedure authorized above. I understand that the practice of medicine and surgery is not an exact science. I understand that there are risks incidental to any medical treatment or procedure and that no guarantees have been made to me as to the results of any examination, treatment, and/or procedure provided to me by the Hospital or any physician.

PERSONAL VALUABLES: I understand and agree that the Hospital can inventory and lock up money and valuables for safekeeping and that the Hospital shall not be liable for the loss or damage to any personal property, unless deposited with the Hospital for safekeeping. Personal property includes, but is not limited to, money, jewelry, glasses, bridges, dentures, hearing aids, watches, documents and furs.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as the patient's representative or as the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Hospital in accordance with the regular rates, terms and charges of the Hospital. The undersigned understands and agrees that the amount is due in full within one hundred twenty (120) days after receipt of the first bill to the patient. Arrangements may be made with the Hospital Patient Accounts department for installment agreements. Private room and guest tray charges are due at time of service.

RELEASE OF INFORMATION: I authorize the Hospital to release all medical information as may be necessary for submission to any third party payer of any claims for payment of services and supplies provided to me.

ITEMIZED STATEMENT: I understand that I may receive an itemized statement of Hospital's bill following formal request to the Hospital's Insurance/Billing Department.

MEDICAL SERVICES BILLING: I understand that I may be billed separately for medical services provided by physicians, including, but not limited to, medical doctors, radiologists, pathologists, anesthesiologists, surgeons, and emergency department physicians. These charges are separate from and in addition to my Hospital bill.

MEDICARE/MEDICAID CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII and 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 a related medical claim. I request that payment of authorized benefits be made on my behalf.

DIRECTORY INFORMATION: I have the right to have or not have certain information included about me in the Hospital's directory. If I am included in the directory, my name, room number in the Hospital, and a one-word statement of my condition may be released by the Hospital to anyone who asks for me by name while I am a patient in the Hospital.

Please Check One: *(Not Applicable if signing for a clinic visit)*

_____I do wish to be included in the Hospital Directory.

_____I do *NOT* wish to be included in the Hospital Directory.

_____(Patient or Representative Initials)

Place Label Here
(straight and centered)

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign to the Hospital, physicians participating in my case, and other licensed providers any and all rights and benefits to which I may be entitled arising out of any healthcare insurance, liability insurance, Medicare, Medicaid or other third party payers. I hold the Hospital harmless from any reduction in health care benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require notification, precertification, prior to retrospective authorization, or utilization review of the medical services I receive. I understand that if I leave the Hospital Against Medical Advice, that payment will not be made to the Hospital by Medicare, Medicaid or other insurance companies. I am financially responsible for all charges, including deductibles and co-insurance, not covered by my policy.

NURSING CARE: I understand that the Hospital provides only general duty nursing care. I understand that I should consult with my physician to determine whether continuous or special duty nursing care is required, and if so, arrangements for such special nursing care must be made by the patient or the patient's legal representative.

PRIVATE ROOM: I understand and agree that Medicare does not cover any private room charge difference unless medically necessary and documented by my physician. If I am assigned to a private room, I understand that I am responsible for payment of the private room difference at the time of service.

TELEPHONE CONSUMER PROTECTION ACT (TCPA): "You agree, in order for us to service your account or to collect any amounts that you may owe us, we may call you at any phone number associated with your account, including wireless numbers, which could result in charges to you. We may also communicate with your by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that 'your office or agent' may contact me as described above."

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of the Hospital's Notice of Privacy Practices.

_____(Patient or Representative Initials)

PATIENT VISITATION is two visitors at a time for admitted patients and one visitor at a time in Emergency Room. Visitors may be restricted following visitation policy.

NOTICE OF HEALTH INFORMATION EXHANGE (HIE) and COMMONWELL ENROLLMENT: The Arkansas State Health Alliance for Records Exchange (SHARE) is an electronic health information exchange that your treating providers use to share health care information about you in order to provide higher quality and better coordinated care. Your health information will be available electronically to your treating providers unless you decide to opt-out and not have your information shared electronically. If you opt-out, your treating providers will not be able to access your health information by making an electronic inquiry through SHARE except in the case of a medical emergency. You have the option to change your mind and terminate your opt out decision. In addition to SHARE, McGehee Hospital participates in COMMONWELL. COMMONWELL compliments the Arkansas HIE in order to share health care information with your treating providers nationwide (not limited to just Arkansas).

_____ I do wish to participate in SHARE & COMMONWELL _____ I do NOT wish to participate in SHARE & COMMONWELL

_____(Patient or Representative Initials)

The above conditions apply to all units within the hospital system, and this form is valid for the length of the admission, including any discharge and readmission to another unit or facility of the hospital during my hospitalization. Assignment of my insurance benefits is valid and binding until final settlement of the account is received. The undersigned certifies that he/she has read this form, has received a copy, is the patient or authorized representative of the patient, and the conditions of admission are fully understood and accepted.

_____ _____

Signature of Patient Signature of Patient's Representative (if applicable) (Also indicate type of relationship, if applicable (i.e. parent / guardian) *

_____ _____

Witness (Admissions Clerk / ER Clerk / Other) Date and Time

*Anyone signing as a "representative" of the patient hereby represents to the Hospital that such person is legally authorized to execute this document by virtue of his/her relationship with the patient as indicated above.