Research Psychiatric Center

Authorizations and Assignments

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Initials

Item 1: Application for Voluntary Admission (to be initialed by patient or legal guardian)
I hereby file with the head of Research Psychiatric Center this request to be admitted as a voluntary patient and agree to submit myself to the custody of Research Psychiatric Center for evaluation, diagnosis, observation, care and treatment medications and rehabilitation for an initial period of no less than 72 hours unless sooner discharged, and thereafter to remain in said Research Psychiatric Center until I am discharged, or until the expiration to seventy-two (72) hours after written request for my release is filed with the head of the facility, or until evaluated by my physician. I agree to abide by Research Psychiatric Center's rules and regulations and understand that violation may result in discharge from the facility.

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Initials

Item 2: Consent to Treatment (to be initialed by patient or legal guardian)
I agree to accept treatment(s) ordered by my attending physician and consulting physicians who she/he may call. I will not be given treatment against my wishes and may discuss my refusal with the attending physician. I understand that supervised students, who are enrolled in a professional training program, may participate in my treatment at Research Psychiatric Center.

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Initials

Item 3: Consent to Emergency Medical and Dental Treatment (to be initialed by patient or legal guardian)
I hereby authorized my attending physician to transfer me to any hospital facility for Emergency Room treatment or performance of a procedure deemed advisable and necessary for any condition that may occur during hospitalization at Research Psychiatric Center, the cost of which, whether billed to the hospital or to the patient directly, shall be paid by the undersigned. I certify that I have read and fully understand the above consent for transfer and for emergency medical and dental treatment, and agree to absolve the referring physician, Research Psychiatric Center, and its staff from liability by reason of such treatment/transfer.

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Initials

Item 4: Disclosure of Required HIV and AIDS Testing (to be initialed by patient or legal guardian)
Missouri law authorizes a hospital or physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, the virus associated with AIDS, in the following situations: (1) if a health care worker is accidentally exposed to a patient's blood or bodily fluids, such as through a needle-stick; or (2) if a medication or surgical procedure is to be performed which should expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you will be asked to submit to testing if any of these situations occur during your hospitalization.

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Initials

Item 5: Transportation Release (to be initialed by patient or legal guardian)
I hereby allow Research Psychiatric Center and its authorized staff to transport me as necessary to other medical facilities, hospitals, physicians' offices, recreational activities, therapeutic interviews or other activities.

Item 6: Release of Patient Valuables and Inventory of Belongings (to be initialed by patient or legal guardian)
It is understood and agreed that the hospital maintains a safe for safekeeping of money and valuables and the hospital shall not be liable for loss or damage to any money, personal valuables or other articles unless deposited with the cashier for safekeeping. I also agree that the Center personnel may inventory my belongings on admission or any time that may be required by my treatment program or any other patient's program at this facility. Research Psychiatric Center reserves the right to determine what items may be introduced into the facility.

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Initials

Item 7: Consent to Photographing (to be initialed by patient or legal guardian)
I understand Research Psychiatric Center requires photographs of me to be utilized by staff to assure I receive the correct treatment as ordered by my attending physician. I understand this is to provide the highest quality of care and to insure my own personal safety.

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Initials

Item 8: Liability Release (to be initialed by patient or legal guardian)
I agree to hold Research Psychiatric Center, Research medical Center and their employees and physicians harmless for any injuries caused by myself while on or off the premises.

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Initials

Item 9: Medical Records Release (to be initialed by patient or legal guardian)
I authorize the release of my medical records to all referring physicians, consulting physicians and/or facilities involved in my aftercare.

Prohibition on Redisclosure: "This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR Part 2) prohibit you from making further disclosures of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

By my signature, I am certifying that I have completely read this consent; that I was given whatever information or explanation I believe was necessary so that I could understand any of the terms or statements contained herein; that all appropriate paragraphs were initialed before I signed the document and that any paragraphs that were not applicable were crossed out before I signed the document.

Patient_____Initials_____Date_____

Witness_____Initials_____Date_____

Guardian/Other Responsible Party

_____Initials_____Date_____

Research Psychiatric Center

Conditions of Admission

1. Consent to Treatment

I consent to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, X-ray examination, diagnostic procedures, medical nursing or surgical treatment or procedures, anesthesia, or hospital services rendered to me as ordered by my physician or other healthcare professional on the hospital's medical staff. I understand that as part of their training, students in healthcare education may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the hospital, and that these students will be supervised by instructors and hospital staff.

2. Financial Agreement

In consideration of the services to be rendered to the patient, I individually promise to pay the patient's account at the rates stated in the hospital's price list (known as "Charge Master") effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement, to pay the patient's account. Some special items will be priced separately if there is no price listed on the Charge Master, or if the charge is listed as zero. An estimate of the anticipated charges for services to be provided to the patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including but not limited to the course of treatment, intensity of care, physician practices and the necessity of providing additional goods and services.

If supplies and services are provided to a patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event, any payment required from the undersigned will be determined by the terms of the governmental program or private health insurance plan. If the patient is uninsured and not covered by a governmental program, the patient may be eligible to have his or her account discounted or forgiven under the hospital's uninsured discount or charity care programs in effect at the time of treatment. You may request information about these programs from the hospital.

As a courtesy to you, the hospital may bill your insurance company but is not obligated to do so. Regardless, you agree that except where prohibited by law, the financial responsibility for the services rendered belongs to you, the undersigned. You also agree that if the hospital must initiate collection efforts to recover amounts owed by you, then in addition to amounts incurred for the services rendered you will pay: (a) any and all costs incurred by the hospital in pursuing collection, including, but not limited to reasonable attorneys' fees and (b) any court costs or other costs of litigation incurred by the hospital that applicable rules or statutes permit the hospital to recover.

The hospital will provide a medical screening examination as required to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, patients who do not qualify under the hospital's charity care policy or other applicable policies are not relieved of their obligation to pay for these services.

3. Release of information

I permit the hospital and the physicians or other health professionals involved in the inpatient or outpatient care to release the healthcare information necessary for treatment, payment or healthcare operations in accordance with state and federal law. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under workers' compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports and discharge summary. This consent specifically includes information concerning psychological conditions, psychiatric conditions, and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

4. Hepatitis/Communicable Disease Testing

The patient is hereby informed in accordance with Section 191.631 of the Missouri Revised Statutes that if the provision of emergency healthcare services to the patient who is delivered to the hospital above directly exposes any person who is employed as an emergency medical care provider, firefighter or police officer to the patient's potentially infectious materials in a manner which may transmit hepatitis in any form and any other communicable disease as defined in Section 192.800 of the Missouri Revised Statutes, except AIDS or HIV infection, then the patient shall be deemed to have consented to testing for such disease(s), and to the release of such test results to the person(s) exposed.

5. Assignment of Benefits

In executing this assignment of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer-, employer group- or trust-sponsored or -offered plan) to pay the hospital and/or hospital-based physicians* directly for the services the hospital and/or hospital-based physicians provided to the patient during this admission. In return for the services rendered and to be rendered by the hospital and/or hospital-based physicians all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which I am entitled services or I am entitled to recover, I understand that nay payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under section 2. This assignment shall be for the purpose of granting the hospital and/or hospital-based physicians an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the hospital and/or hospital-based physicians to pursue any such right of recovery. In no event will the hospital and/or hospital-based physicians retain benefits in excess of the amount owed to the hospital and/or hospital-based physicians for the care and treatment rendered during the admission. If a third-party payer (such as an insurance company or employer group- or trust-sponsored or -offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the hospital and/or hospital-based physicians in collecting payment from any such third-party payer. I hereby appoint the hospital as my authorized representative to pursue, if it so chooses, all administrative remedies, claims and/or lawsuits on my behalf and at the hospital's election, against any responsible third-party, medical insurer, or employer-sponsored medical benefit plan for the purposes of collecting any and all hospital benefits due me for the payment of the charges referred to in section 2 above. If the hospital elects to pursue a claim or lawsuit against a third-party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the hospital to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the hospital to bring suit against the third-party payer in my name. I agree to pay over to the hospital immediately all sums recovered in any claim or lawsuit brought on my behalf by the hospital (up to the amount of the hospital's charge, plus expenses and attorneys' fees). I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the hospital and/or hospital-based physicians.

*Hospital-based physicians include but are not limited to: emergency department physicians, pathologists, radiologists, anesthesiologists. These services are rendered by independent contractors and are not part of the hospital bill. These services will be billed separately by each physician's billing office.

6. Private Room

I understand and agree that I or the party responsible for payment for hospital and medical services is responsible for any additional charges associated with the request and use of a private room.

7. Communications About My Healthcare

I authorize my healthcare information to be disclosed for purposes of communicating results, findings and care decisions to my family members and others responsible for my care or designated by me. I will provide those individuals with a password or other verification means specified by the hospital.

8. Medicare Patient Certification and Assignment of Benefit

I certify that any information I provide in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorize benefits to made on my behalf to the hospital or hospital-based physician(s) by the Medicare or Medicaid program.

9. Patient Self-Determination Act

I have been furnished information regarding advance directives (such as durable power of attorney for healthcare and living wills). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay at the hospital.

_____ I executed an advance directive and have been requested to supply a copy to the hospital.

_____ I have not executed an advance directive.

_____ I wish to execute an advance directive.

_____ I do not wish to execute an advance directive.

10. Notice of Privacy Practices

_____ *Initials* I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the hospital Privacy Official designated on the notice if I have a question or complaint.

11. Other Acknowledgements

a. **Legal Relationship Between Hospital and Physicians**
Most or all of the healthcare professionals performing services in the hospital are independent contractors and are not hospital agents or employees. Independent contractors are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent contractors. I understand that physicians or other healthcare professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by, all physicians or healthcare professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EDG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate form the bill for hospital services.

b. **Personal Valuables**
I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars ($500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the patient.

c. **Weapons/Explosives/Drugs**
I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

I, the undersigned, as the patient, or the parent, guardian, spouse, guarantor or agent of the patient, hereby certify I have read, and fully and completely understand this Conditions of Admissions and Authorization for Medical Treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to bound by its terms. I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

❑ Patient is medically unable to sign the Conditions of Admission ❑ Patient refused to sign the Conditions of Admission

Patient/Parent/Guardian** _____ Date_____ Time_____

Spouse (if married/available)_____ Date_____ Time_____

Witness to signature_____** If other than patient, indicate relationship

Research PSYCHIATRIC CENTER
A campus of **Research** MEDICAL CENTER