Patient Name:
Med Rec Number: Acct Number:
Age: Gender: DOB: Svc Date:

CONDITIONS OF ADMISSION AND TREATMENT / INDEPENDENT CONTRACTOR DISCLOSURE

I,____, am presenting to Pinckneyville Community Hospital for medical and/ or surgical care, or to Family Medical Center for primary and specialty care (collectively referred to as Pinckneyville Community Hospital or Hospital).

1. **Consent for Treatment:** I consent to the providing of medical and/or surgical care by my physician, consulting physicians, and other health care providers including, but not limited to diagnostic and therapeutic tests and procedures and treatment as may be ordered by my health care provider, and/or his/her designees including consulting health care providers. This consent includes but is not limited to the performance of invasive diagnostic procedures, administration of fluids, medications and any radiology procedures.
2. **Emergency Room Services and EMTALA (Emergency Medical Treatment and Labor Act):** Pinckneyville Community Hospital shall not deny emergency room services to a person who needs them but cannot pay for them. I understand that Hospital shall treat medical emergencies regardless of my ability to pay. If I or my guarantor have a medical emergency or if I am a pregnant woman in labor, I have the right to receive, within the capabilities of this Hospital's staff and facilities, an appropriate medical screening exam, stabilizing treatment, and, if medically necessary, an appropriate transfer to another hospital, even if I cannot pay or do not have medical insurance.
3. **Patient Rights & Responsibilities:** Pinckneyville Community Hospital provides a copy of the Patient Rights & Responsibilities to patients in the inpatient and swing bed admission packet. Signature on this consent form serves as acknowledgement of patient receipt. The Patient Rights & Responsibilities are also posted on the Hospital's website at www.pvillehosp.org.
4. **Valuables/Personal Items:** I agree to deposit money, jewelry, and other valuables with Hospital for safekeeping, or to send them home. If I choose to keep any such valuables or any personal items such as dentures, eyeglasses, contact lenses, etc., I assume responsibility for them.
5. **Weapon/Explosives/Drugs:** I understand and agree that if the Hospital at any time believes there may be a weapon, explosive device, biohazard material, any type of illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Hospital may search my room and belongings, confiscate any of the above items that are found, and dispose of them as the Hospital determines appropriate, including giving them to law enforcement.
6. **Insurance Coverage & Financial Responsibility:** I authorize my insurance company or organization to pay benefits directly to the Hospital, this being my assignment of benefits to said corporation. I do hereby authorize the Chief Financial Officer of Hospital to endorse for me any checks made payable to me for benefits or claims collected on this assignment and for the Hospital to apply any credit balance to any other account I may owe said Hospital. I understand that I am obligated to promptly respond to any insurance company inquiries for additional information in order to process my claim. I also understand that it is my responsibility as the patient to know and understand my insurance benefits including any coverage limits. I understand that all patient portion amounts, including non-covered services, are due upon request and are payable to Hospital. If you fail to pay on time and we refer your account(s) to a third-party for collection, a collection fee will be assessed and will be due at the time of the referral to the third-party. The fee will be calculated at the maximum percentage permitted by applicable law, not to exceed 25 percent. I also hereby give authorization to Hospital to verify employment and credit history report on myself or responsible guarantor as part of those reasonable collection efforts.
7. **Phone Number Usage Consent:** For us to service your account or to collect any amounts you may owe, you agree the Hospital, including its collection agency and legal counsel, may contact you or your spouse by telephone, and may leave voicemail messages, at any telephone number associated with your account, including wireless (cellular) telephone numbers which could result in charges to you, as well as telephone numbers of guarantors, insurance subscribers and emergency contacts listed on your account. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable.
8. **Texting and Email Notifications:** In order to provide you with the best possible care, we occasionally send convenient text messages and emails to our patients about appointment reminders, prescription order placements, wellness checkup reminders, pre-registration discussion, pre-operative instructions, lab result notifications, and post-discharge follow up, including collection or billing matters. Your wellness is important to us, and we may also send you notifications about health care services that we offer including new service announcements, community education events and special events. Our goal is to provide you with relevant and useful information for improving your health. If you have provided your email and cell phone information upon registration, you hereby acknowledge consent to be contacted via email and text.

9. **For Medicare/Medicaid Beneficiaries Only:** I certify that the information given by me in applying for payment under Titles XVIII & XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished me by, or in Hospital, including physician services. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information necessary to determine these benefits or related services.

10. **Recordings, Film and Other Images:** I authorize and consent to the production or use of photographs, recordings, films, or other images of me (i.e. any photographic, video, electronic, or audio media) for purposes of identification, diagnosis or treatment in connection with the care provided to me by my attending physicians(s) or personnel from Hospital, including distant site providers via tele-health technology. Photographs for identification and clinical purposes are incorporated as part of the patient's medical record. I understand photographs, recordings, films or other images of me are considered protected health information (PHI) with the same protections as the patient's medical record and further consent to the use of my PHI for internal educational, training, performance improvement, and patient safety purposes at Hospital. I am not providing my consent to the use of recordings, films or other images of me for external use (i.e. those that may be intended to be heard or seen by the public), and understand that a separate consent must be obtained from me before any such use occurs.

11. **Release of Information:** I authorize Hospital to disclose all or any part of the patient's record to any person or corporation, which is or may be liable under a contract with Hospital or the patient for charges. This release includes the diagnosis, treatment and/or hospitalization for mental health, alcohol and/or drug abuse. *This release also includes the results of any blood test performed to determine the presence of the HIV virus (causative agent of AIDS), and/or the diagnosis and/or treatment of AIDS.* In addition, I authorize any health care provider, including any physicians and facilities to which the patient may be transferred, to provide information to Hospital or its designee upon request, concerning the patient's care, condition, and treatment, for quality improvement or risk management purposes. I further authorize Hospital to give verbal and/or written information to agencies or physicians continuing medical care to the patient following transfer or discharge from any Hospital service.

12. **Patient Directory:** I have been informed that it is customary for the Hospital to have a Patient Directory for use by staff to inform visitors inquiring as to my location and general condition and for use by local clergy. I understand that it is not Hospital policy to share patient names with news media. However, if the news media asks about me by name, Hospital policy allows release of my general condition. By signing below, I hereby give consent for my name to be listed in the Hospital's Patient Directory.

13. **Patient Portal:** I understand that I have the option to provide Hospital with an email address permitting an email invitation to the Patient Portal. I also understand that by providing an email address, I am consenting and understand that once information has been processed through secure electronic portals by me, I am responsible for the Confidentiality and Security of said information.

14. **Students:** Pinckneyville Community Hospital cooperates with colleges/universities to provide clinical experience to students. As a result, students may be observing and participating in patient care. You have the right to refuse a student being present and/or providing care during your treatment.

15. **External Pharmacy:** I agree and give consent to exchange prescription information between the facility and my pharmacy(ies).

16. **Video Taping/Recording:** I agree not to photograph, video record, audio record, or otherwise capture imaging or sound on any device unless otherwise authorized. I also understand it is my responsibility to assure my visitors comply with this requirement.

17. **Telehealth and Telemedicine:** I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time without affecting my right to future care or treatment. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative(s) medical care options to my satisfaction. I hereby verbally authorize my healthcare provider to use telemedicine/telehealth in the course of my diagnosis and treatment.

18. **CommonWell Network:** By signing this consent, it is agreed and acknowledged that Pinckneyville Community Hospital may share information through CommonWell when you seek emergency room services, and when you are admitted for further treatment. CommonWell is an informational network that provides participating practitioners access to a comprehensive view of your health history to help make better decisions and to better coordinate care across your healthcare teams. Hospitals, clinics, and providers who participate in CommonWell can access your health record to provide comprehensive and coordinated care. If you are unable to provide health data, your care team may be able to locate it immediately through CommonWell. If you desire additional information on ComonWell or wish to opt out, please notify the Registration Clerk.

19. **Privacy Notice, Patient Bill of Rights and Understanding Balances Due Brochure:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our privacy notice before signing this consent. The Patient Bill of Rights provides patients with information on how you can reasonably expect to be treated during the course of your hospital stay and treatment. The Hospital also provides information on Understanding Balances Due For Services, Billing & Collection Procedures and Your Payment Options. By signing this form, you acknowledge that we have notified you of this information posted in our facility, on the hospital website or provided in your admission packet when applicable, and have provided a copy upon request. By initialing here, you have acknowledged we have informed you of these documents and have offered printed copies.

    The CMS Interoperability and Patient Access Final Rule requires hospitals to send electronic event notifications of admissions and discharges to/from emergency department and inpatient units to your provider(s). This data is exchanged through secure platforms. By initialing here, you consent to the transfer of this data

    Initial

    Initials: ________________

20. **Independent Contractor Disclosure: Relationship of Physicians & Advanced Practice Professionals ("Providers") to Pinckneyville Community Hospital:**

    The following Providers are employed by Pinckneyville Community Hospital:

    - Family Medical Center providers including Family Practice, Internal Medicine, General Surgery, and Advanced Practice Professionals
    - Dr. John Gregg Fozard, who works in the Family Medical Center and Hospital Inpatient setting
    - Dr. Christopher Reyes, who works in the Family Medical Center and Hospital Inpatient setting
    - Dr. Andrew Forbes, who works in the Family Medical Center and Hospital Inpatient setting
    - Dr. Sabrina Haque, who works in the Family Medical Center, Hospital Inpatient setting, and Emergency Department
    - Leah Hopp, NP-C, Nurse Practitioner Hospitalist
    - Chelsea Kuhnert, NP, Nurse Practitioner Hospitalist
    - Shakeel Sandozi, M.D., General Surgeon
    - Gloria Przygoda, DNP, FNP-C, Wound Care Provider
    - Dr. Sharon White-Findley, who works in the Family Medical Center and Hospital Inpatient Setting
    - Dr. Alexander Workman, who works in the Family Medical Center and Hospital Inpatient Setting

    All other Providers on staff at this Hospital including, but not limited to attending physicians, emergency department physicians, pathologists, radiologists, anesthesia providers, consulting physicians, and specialty clinic providers, are independent contractors and are NOT employees or agents of the Hospital. If the Hospital bills for the professional services provided by independent contractors, it is done so per contractual agreement and to provide a consolidated billing statement for the convenience of the patient.

    I acknowledge that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of Pinckneyville Community Hospital for my care. Further, I understand that physicians practice Independent medical judgement in my care and treatment. I acknowledge that any questions about the Independent Contractor Disclosure form and the important information contained in it have been answered to my satisfaction.

    Initial

    Initials: ________________

21. **Notification of Payer Participation/Non-Participation and Non-covered Services:** Prior to receiving any non-emergency services, you should contact your insurance plan to verify that the provider and/or physician is listed as a participating provider and if the services received are covered under your benefit plan. Even if the Hospital or practitioners providing services here are contracted to participate with an insurance plan network that does not always guarantee that in-network status applies to your particular insurance plan. Your insurance plan may have a particular narrow network arrangement or require particular services to be obtained from a limited set of providers they approve. The Hospital is not going to know all the specifics of your particular plan. Therefore, if you receive services here, you are strongly encouraged to call the toll free telephone number on your insurance identification card to verify in-network and coverage status of services you are receiving. Be aware that when you elect to utilize the services of a non-participating provider for anything other than emergency services or services approved by the insurer in advance, the basis of your benefit payment will be determined according to your insurance policy's "out-of-network" fee schedules, which will result in greater financial responsibility to you. Furthermore, if your plan does not cover specific services, or requires that you obtain certain services through only specific approved providers, you will be responsible for payment for any services deemed to be non-covered or out-of-network by your benefit plan. By signing this consent, you assume responsibility for verification of in-network status and are responsible for any services that your insurance plan processes as out-of-network or non-covered.

I certify that I have read and received a copy of the foregoing as the patient or as a duly authorized representative of the patient as the patient's general agent to execute the above and accept its terms.

Click here to sign

Patient or Patient's LegalAgent or Representative, Date & Time

Indicate Relationship

Verbal Consent or Patient unable to sign due to: ______

1st Witness Signature

1st Witness Title

2nd Witness Signature

2nd Witness Title

Nondiscrimination Notice

Pinckneyville Community Hospital and Family Medical Center complies with applicable Federal civil rights laws and do not discriminate against any person on the basis of race, color, sex, national origin, disability (physical or mental), religion, age, sexual orientation, gender identity, sex stereotyping, pregnancy or status as a parent, in admission, treatment, or participation in its programs, services and activities, or in employment.

Pinckneyville Community Hospital provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign and foreign language interpreters and other assistive devices. If you need these services contact any employee, or Hospital Administration, at phone number 618-357-5904.

If you believe that the Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Director of Quality and Risk Management, P.O. Box 437, Pinckneyville, IL 62274, Phone: 618-357-5976, Fax: 618-357-8888, or Email at qualityimprovement@pvillehosp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director of Quality and Risk Management is available to help you.

If you believe that the Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Director of Quality and Risk Management, P.O. Box 437, Pinckneyville, IL 62274, Phone: 618-357-5976, Fax: 618-357-8888, or Email at qualityimprovement@pvillehosp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director of Quality and Risk Management is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Limited English Proficiency Taglines

As required to meet compliance with Section 1557 of the Affordable Care Act (ACA)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-618-357-2187 (TTY: 7-1-1).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-618-357-2187 (TTY: 7-1-1).

For more information about language assistance services and proficiency taglines, please visit www.pvillehosp.org