



## Animas Surgical Hospital, LLC

**Consent for Admission:** I request and consent to admissions to the Animas Surgical Hospital and have received a copy of the hospital's NOTICE OF PRIVACY PRACTICE and the PATIENT BILL OF RIGHTS explaining my rights as a patient.

**Consent to Medical and Surgical Procedures:** The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, which may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services rendered to the patient under the general and special instructions of the patient's physician or surgeon.

**Consent for Testing for Purposes of Accidental Exposure:** The undersigned consents to acknowledgment of state law which allows that in the event a health care worker is exposed to my blood or body fluids during my admission, my blood shall be tested at no cost to me, using a special coded system to ensure confidentiality, for the HIV antibody and other communicable diseases. If such exposure occurs, I will receive additional information about such tests. The results of these tests will not prejudice my patient relationship with Animas Surgical Hospital, LLC.

**Nursing Care:** This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient needs more intensive nursing care. If the patient's condition requires the service of a special duty nurse, it is agreed that such an arrangement will be made by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such additional care. Bedrails will be utilized on all patients for their protection.

**Teaching Programs:** I understand that I may be seen and examined by supervised students as a part of the educational program, but reserve the right to limit my participation at any time.

**Legal Relationship Between Hospital and Physician:** All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, for the medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the physician. I am aware that Animas Surgical Hospital, LLC is a private, for profit organization and meets the Federal definition of a physician-owned hospital specified in Sec. 489.3. As such, the surgeons, administrator and anesthesiologists who are owners of the hospital have a financial incentive to perform surgeries at the hospital. The physician of the hospital are: Field Blevins, MD., Mark Forrest, MD., Moss Fenberg, MD., Gareth Hammond, MD., Frank Mayer, MD., Patrick McLaughlin, MD., Eric Meyer, MD., Ryan Naffziger, MD., Brince Phipps, MD., Nicole Pinkerton, MD., Ronald Ritz, MD., Chris Roach, MD., David Silva, DO., Philip Wiley, MD., and Joshua Zastrocky, MD.

**Release of Information:** I also authorize the Animas Surgical Hospital to release all medical information necessary to process any claims related to my hospital care. I also acknowledge that I have received a copy of Animas Surgical Hospital's Notice of Privacy Practice.

**Advance Directives:** The patient, or his or her representative, hereby acknowledges that they have been provided with information regarding patient rights and patient rights to prepare an advance directive.

Do you have an Advance Directive or Living Will? ☐ Yes ☐ No

Do you have a Medical Durable Power of Attorney? ☐ Yes ☐ No

The Hospital's Advanced Directive Policy has been made available to me ☐ Yes ☐ No

Do you have a legal guardian? ☐ Yes ☐ No If yes, guardian's name: \_\_\_\_\_

Do you have a DNR (Do Not Resuscitate) Order? ☐ Yes ☐ No If yes, it is the policy of Animas Surgical Hospital to **initiate life saving resuscitative measures during and immediately following all procedures and I hereby consent to these measures.**

\_\_\_\_\_  
Signature of Patient, Parent, Legal Guardian or other Legal Representative

**Personal Valuables:** It is understood and agreed that the hospital shall not be liable for the loss or damage of any personal property.

**Financial Agreement:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient he/she hereby individually obligates himself/herself to pay the account(s) of the hospital and any ancillary charges in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

**Assignment of Insurance Benefits:** The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of any insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's actual charges. It is agreed that payment to the hospital, pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not paid pursuant to this assignment. Further, I understand that ANESTHESIOLOGY, EMERGENCY PHYSICIAN and OTHER PHYSICIAN SERVICES, PATHOLOGY, RADIOLOGY and some LABORATORY SERVICES may bill me separately. It is also understood that if any implants are used that I will be responsible for payment and I could be balance billed.

**Transfer:** I understand that there may be circumstances occurring as the result of surgery or anesthesia that may require admission to an extended care facility or transfer to a different healthcare facility and that I will be responsible for any charges related to services of that facility and the transportation to such facility that are separate and distinct from the Animas Surgical Hospital. I understand that I am responsible for such charges.

**Healthcare Service Plan Obligation:** This hospital maintains a list of healthcare service plans with which it contracts. A list of such plans is available upon request from the financial office. The hospital has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by the hospital if he/she belongs to a plan which does not appear on the above mentioned list.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

\_\_\_\_\_  
Signature of Patient, Parent,  
Legal Guardian or other Legal Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Please Print Name of Patient  
Parent, Legal Guardian or other Legal Representative

\_\_\_\_\_  
Signature of Guarantor

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Please Print Name of Guarantor

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Please Print Name of Witness