Animas Surgical Hospital — Conditions of Admission – Form

Eff 12.2004
Rr. 4/2019

Consent for Admission: I request and consent to admissions to the Animas Surgical Hospital, DBA Animas Internal Medicine, Animas Urgent Care, Animas Occupational Medicine, and/or Animas Physician Network. Also, I understand the hospital's ADVANCE DIRECTIVE POLICY, NOTICE OF PRIVACY PRACTICE, the PATIENT BILL OF RIGHTS and the NOTICE TO PATIENTS OF RIGHT TO COMPLAIN OR FILE A GRIEVANCE explaining my rights as a patient have been made available to me.

Consent to Medical and Surgical Procedures: I consent to the procedures which may be performed during this hospital visit, including emergency treatment or services, which may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment(s) or procedure(s), anesthesia, or other hospital services rendered to the patient under the general and special instructions of the patient's provider or surgeon.

Consent for Testing for Purposes of Accidental Exposure: In the event a health care worker is exposed to my blood or body fluids during my admission, I acknowledge the state law which allows my blood to be tested for the HIV antibody and other communicable diseases. The testing will be at no cost to me and use an anonymous coding system to ensure confidentiality. 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 provider, 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 more intensive nursing care and is hereby released from all liability arising from the fact that said patient is not provided with such additional care.

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: Most providers and surgeons furnishing services to the patient, including radiologists, pathologists, anesthesiologists 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 provider and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such provider. It is the responsibility of the patient's provider or surgeon to obtain the patient's informed consent, when required, for medical or surgical treatments, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the provider. 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 who are owners of the hospital have a financial incentive to perform surgeries at the hospital. The physician owners of the hospital are: Field Blevins, MD, Brian Butzen, MD, Mark Forrest, MD, Moss Fenberg, MD, Gareth Hammond, MD, Sarah Haug, MD, Nicolas Hugentobler, DPM, Kayse Lake, DPM, Patrick McLaughlin, MD, Eric Meyer, MD, Ryan Naffziger, MD, Brince Phipps, MD, Nicole Pinkerton, MD, David Silva, DO, Karyn Teel, MD, Philip Wiley, MD, Jeffrey Williams, DO, and Joshua Zastrocky, MD.

Release of Information: I authorize Animas Surgical Hospital to release all medical information necessary to process any claims related to my hospital care.

Advance Directives: I hereby acknowledge that I have been provided with information regarding patient rights and patient rights to prepare an advance directive. I understand that for the patient's wishes to be made known it is my responsibility to provide the hospital with a copy of the patient's advanced directives.

Does the patient have an Advance Directive or Living Will? ☐ Yes ☐ No
Does the patient have a Medical Durable Power of Attorney? ☐ Yes ☐ No
Does the patient have a DNR (Do Not Resuscitate) Order? ☐ Yes ☐ No
Does the patient have a legal guardian? ☐ Yes ☐ No If yes, guardian's name:_____

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: I agree, whether I sign as the agent or as the patient, to hereby individually obligate myself to pay the account(s) of the hospital and any ancillary charges in accordance with the regular rates and terms of the hospital for services rendered to the patient. Should the account be referred to an attorney or collection agency, I shall pay actual attorneys' fees and collection expenses. Delinquent accounts may bear interest at the legal rate. I consent to receive calls from the hospital, or its designee, on any number provided to the hospital, including my wireless number, and that such calls may be charged by my wireless carrier and may be generated by an automated dialing system. I understand that if I NEED HELP PAYING THESE HOSPITAL BILL(S) I may apply for financial assistance by calling 970.385.2373 or visiting https://www.animassurgical.com/patients-visitors/financial-assistance/

Assignment of Insurance Benefits: I authorize, whether I sign as the agent or as the patient, direct payment to the hospital of any insurance benefits otherwise payable to or on behalf of the patient for this hospital visit, 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. I understand that I am 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, and I am responsible for such third-party bill(s).

Transfer: I understand that there may be circumstances occurring as the result of the patient's condition, surgery and/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 Animas Surgical Hospital.

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. I agree that I am individually obligated to pay the full charges of all services rendered to the patient by the hospital if he/she belongs to a plan which does not appear on the above mentioned list and/or belongs to a plan where Animas Surgical Hospital is excluded from participation.

I certify that I have read the foregoing, received a copy thereof, and am the patient, the patient's legal representative, or am 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