**ADMISSION AGREEMENT**

1. Consent To Admission and Treatment

I voluntarily agree to the provisions of this **Consent** regarding my admission and treatment as a patient at Pinnacle Hospital (the “**Hospital**”). As part of the course of my care and/or diagnosis and treatment of my medical or surgical condition, I consent to the administration of medications, tests, procedures, services, items and hands-on care and to physical examinations (collectively “**Care**”) by physicians practicing at the Hospital (“**Physicians**”) and other Hospital personnel (“**Care Providers**”). I agree to follow all rules and regulations of the Hospital related to patient and visitor conduct and safety.

I understand that I may revoke this Consent at any time by providing written notice to the Hospital. My revocation will be effective upon receipt by the Hospital unless I specify a later date. However, I acknowledge that my revocation will not have any effect on any action taken by the Hospital in reliance on this Consent before the Hospital received my revocation. I understand that if I refuse to give this Consent or revoke this Consent, the Hospital may refuse to provide treatment to me where permitted by law.

2. Assignment of Benefits

The Hospital may agree to accept an assignment of my insurance plan benefits. If the Hospital agrees to such assignment, I acknowledge that my Care has been and/or will be rendered by the Hospital and my Physicians and/or Care Providers, and that I may be entitled to receive payment for my Care under one or more health insurance plan(s) (“**Insurance Plan(s)**”) or any claim I might assert against others because of my injuries (my “**Claim**”). In consideration of my Care rendered or to be rendered for this admission and treatment and/or any subsequent related admission and treatment, including, but not limited to, inpatient, outpatient, or clinical visits, I hereby irrevocably assign and transfer to the Hospital all right, title and interest in all benefits or monies payable for Care rendered, including but not limited to: group medical, indemnity, self-insured or ERISA benefits or coverage; PIP; UIM/UM; auto or homeowner insurance. It is further agreed and understood that the obtaining of verification of benefits and/or pre-certification does not relieve me of any liability for the financial responsibility for goods and services provided or to be provided to me by the Hospital, Physicians and Care Providers. Even though I have assigned my rights under my Insurance Plans, I acknowledge that it is my responsibility to follow up with my Insurance Plan regarding payment if any claim related to my Care is not paid within forty-five (45) days of submission. I agree to execute all forms that the Hospital, my Physicians, my Care Providers or my Insurance Plan deem necessary or beneficial in order to enable the Hospital and my Physicians and/or Care Providers to apply for and obtain such payment.

3. Assignment of Benefits for Medicare Beneficiaries

In consideration of my Care furnished by the Hospital, my Physicians and Care Providers, I assign to the Hospital, my Physicians and Care Providers payment of any Medicare benefits otherwise payable to me for my Care. I authorize any holder of medical or other information about me to release to Medicare and its agents and contractors any information needed to determine Medicare benefits or other benefits for my Care. I agree to execute all forms that the Hospital, my Physicians, my Care Providers or Medicare deem necessary or beneficial in order to enable the Hospital and my Physicians and/or Care Providers to apply for and obtain such payment.

4. Exposure of Hospital Personnel

If employees of the Hospital, students studying at the Hospital, my Physicians or any Care Providers (collectively, “**Hospital Personnel** ”) are exposed to my blood during the course of my Care (an “**Exposure**”), the Hospital may request that my blood or other body fluids be tested for the Human Immunodeficiency Virus (“**HIV**”), hepatitis, and/or other transmittable blood borne infections (“**Blood borne Infections**”). I have the right to refuse such a request and I have indicated (by checking the appropriate box below) my consent to such request for the tests or my refusal to consent:

 I consent to having my blood drawn to check for Blood borne Infections in case of an Exposure.

 I DO NOT consent to having my blood drawn to check for Blood borne Infections in case of an

Exposure.

5. Personal Property and Valuables: Limitations on Liability

I acknowledge that the Hospital is not responsible for the loss of or damage to my personal property and that I am solely responsible for my personal property, including but not limited to, money, eye glasses, contact lenses, dentures, etc. I acknowledge that, if the Hospital permits, I may deposit personal property with the Hospital for safe storage in accordance with the Hospital’s policy.

6. Acknowledgement of Notice of Privacy Practices

I acknowledge that I have received a copy of the Hospital’s Notice of Patient Privacy Practices, which describes the permitted uses and disclosures of health information related to my Care by the Hospital, my Physicians and Care Providers.

7. Status of My Physicians or Care Providers

I understand that not all my Physicians and Care Providers practicing at the Hospital are employees of the Hospital, that non-employed Physicians and Care Providers provide service as independent contractors, and that the Hospital is not responsible for the Care provided to me by non-employed Physicians and Care Providers.

8. Advance Directives

* I DO have Advance Directives Copy provided Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_
* If copy not provided, was copy requested Yes \_\_\_\_\_ Date \_\_\_\_\_\_ N/A \_\_\_\_

 Do we have the current Advance Directives Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_

 Have there been any recent changes Yes\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

* I DO NOT have Advance Directives
* I would like the Hospital to provide me with more information regarding Advance Directives

I acknowledge that I have had an opportunity to record with the Hospital my current preferences for Advance Directives by filing a new form or a copy of my previous Advance Directive and that the Hospital, my Physicians and Care Providers are not responsible for administering Advance Directives as to which the Hospital has not been expressly and properly notified.

9. Patient Rights

I acknowledge that I have been provided with a copy of the Hospital’s Patient Rights information.

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| --- | --- |
| **Patient Initials** | X |

10. Disclosure of Physician Ownership in the Hospital or Pinnacle Healthcare LLC

I acknowledge that my signature on this form is evidence of my receipt of the following disclosure pertaining to a Physician’s or medical practice’s ownership or financial interest, or both, in the Hospital or Pinnacle Healthcare LLC. The following Physician(s) and/or medical practices maintain an ownership interest or financial interest, or both, in the Hospital or Pinnacle Healthcare LLC:

Name of Physician/Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address/City/State/Zip Code

Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may choose to be referred to another facility or health care entity. For further information concerning such ownership interest, I understand that I can contact the physician or medical practice administrator at the addresses and telephone numbers shown above.

11. Guarantor Agreement

To the extent permitted by federal and Indiana law, the undersigned agrees that where he or she signs as the parent, spouse, legal guardian, legal representative, agent or other individual or entity, on behalf of the named patient (“**Patient**”), the undersigned individually guaranties payment of any and all Hospital, my Physicians and Care Providers charges incurred by the Patient during this admission and treatment or subsequent related admissions and treatments, including but not limited to, inpatient, outpatient, or clinical visits, at the Hospital. This is an absolute guaranty and it shall continue as long as any balance is still due and owing to the Hospital, my Physicians and Care Providers. The undersigned waives any exemptions from garnishment, attachment, or legal process in favor of Hospital, my Physicians and Care Providers to the extent permitted by federal or Indiana law.

Having read the above, I accept all the provisions of this Consent and my signature below is evidence of my acceptance.

|  |  |
| --- | --- |
| **Patient’s Name (Please Print)** | X |
| **Parent/ Legal Representative Name (Please Print)** |  |
| **Patient/Parent/Legal Representative Signature** | X |
| **Relationship if not the Patient** |  |
| **Date and Time of Signature** | **□ A.M.****□ P.M.** |
| **Witness’ Signature** |  |
| **Name of Witness (Please Print)** |  |