

**Advance Directive/Living Will** Written information has been handed to me concerning the patient's rights and responsibilities. The patient has a right to formulate an advance directive (Living Will) and Oklahoma Surgical Hospital, LLC (OSH) will carry out the patient's wishes for medical treatment. I understand that an advanced directive (Living Will) is not required for admission or to receive treatment at OSH.

**Patient has Living Will/Advance Directive** yes no **Living will/Advance Directive received** yes no

**Consent to Diagnostic/Medical Treatment** OSH and its medical staff are hereby authorized to administer any necessary or advisable medical, diagnostic, anesthetic or therapeutic treatment and to dispose of any tissue, body part or organ removed during the course of treatment for this admission or outpatient visit. I (patient) have the right to consent to any procedure and plan of treatment, except in the event of an emergency or an extraordinary circumstance.

**Patient Rights and Responsibilities** I hereby acknowledge receipt of the Patient Rights and Responsibilities.

**Important Message from Medicare** I hereby acknowledge receipt of the Important Message from Medicare (**Medicare patients only**)

**Release of Information** OSH physicians and attendants may disclose patient information about this admission or outpatient visit to others for the purpose of payment, treatment, or health care operations. The Notice of Privacy Practices provides additional important information regarding the use and disclosure of patient medical information by the hospital physicians and attendants. I hereby acknowledge receipt of the Notice of Privacy Practices. I understand that I have the right to request restrictions on certain uses and disclosures of my personal information.

**I hereby authorize/prohibit (circle one) release of the following information to individuals asking for me by name:**

My name My location in the facility My condition described in general terms (fair, serious, critical) My religious affiliation (clergy only)

**Alternate Means/Location of Communication**

I hereby request to receive communications of protected health information via \_\_\_\_\_ or at this location \_\_\_\_\_.

**Assignment of Insurance or Other Benefits** Assignment of all hospital benefits of any kind or entitlement is hereby made to OSH. Assignment of medical benefits of any kind or entitlement is hereby made to the physician or medical group providing care during the admission. It is understood and agreed that the patient/guarantor or the undersigned custodian(s) of a minor patient, are financially responsible for any deductible, co-payment and all charges for services or goods not paid for or provided by health care benefits, plans or entitlements. I also assign and transfer to OSH the rights to pursue all appeals available through the highest appeal level offered by the payor. This assignment shall not be construed to be an obligation on the part of OSH to pursue any such rights of appeal and/or recovery. I also authorize OSH to apply and credit any overpayment made to OSH, which would otherwise be payable to the patient, against any previous balance owed to OSH for which the patient is the responsible party.

**Financial Agreement** The patient/guarantor agrees to pay to OSH all amounts due in consideration of services and supplies rendered by the hospital, except for charges for services which are not paid for or provided by health benefit plans or entitlements. . Hospital charges for services or goods shall be based on the billed-charge rate, unless otherwise agreed to in writing by OSH. OSH's acceptance or check endorsement of less than payment in full at any time shall not waive OSH's right to collect remaining balances on any account, unless agreed to in a separate writing by OSH. If any payment is made directly to me for services billed by OSH, I will promptly remit to OSH. It should be noted that non-participating providers under the patient's health plan may be subject to reimbursement differences as out-of-network providers. Therefore, all patients are encouraged to ask their insurance company to include this facility as an in-network provider. This inclusion should eliminate any differences the patient would have enjoyed as an in-network patron.

**Release of Responsibility for Valuables/Non-Hospital Owned Equipment** There is a safe at OSH available to patients for safekeeping of valuables and personal property. OSH is hereby released of responsibility or liability for any theft, loss or damage to valuables or personal property (i.e., eyeglasses, dentures, hearing aides, jewelry) that are retained in the possession of the patient during the hospital admission or outpatient visit. Further, OSH is released from responsibility or liability for injury or loss which may occur in or out of the hospital arising out of a patient use of non-hospital-owned or supplied, electrical or mechanical equipment or device.

**Information Release for Medical Devices** In order to communicate any equipment notices, the manufacturer of medical devices or implants may need the Social Security number of patients receiving these items in the hospital. If I receive a medical device during my stay or visit to OSH, I hereby authorize the release of my Social Security number to the manufacturer, in accordance with federal law.

**I WAS GIVEN THE OPPORTUNITY TO READ OR HAVE READ TO ME THE ABOVE AGREEMENT AND MY CONSENT TO THESE TERMS IS GIVEN BY MY SIGNATURE:**

**Patient/Authorized Person Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Reason Patient Unable to Sign:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_

