Medical Record Number

Patient Name

Addressograph or Label

Please read this document carefully. Stanford Health Care (hereafter SHC) requires the Terms and Conditions of Service to be signed in its entirety, without alteration.

1. MEDICAL CONSENT. I, the undersigned, consent to the general treatment and procedures that may be performed during this hospitalization or as an outpatient (including emergency services). These procedures may include but are not limited to laboratory procedures, x-ray examinations, medical or surgical treatment or procedures, anesthesia, or hospital services provided to the patient under the general and special instructions of the patient's physician or surgeon. I also authorize SHC to use and/or dispose, at its discretion, any blood, bodily fluid, member, organ, or other tissue removed or obtained during an operation, procedure or treatment, for research that may be conducted by SHC, Lucile Packard Children's Hospital, Stanford University, or unaffiliated academic or commercial third parties if allowed under legal requirements and Stanford policies. I understand that it is the responsibility of the patient's physician to obtain the patient's informed consent when required for specific medical or surgical treatment and special diagnostic or therapeutic procedures. I understand and agree that at the request of the attending physician, allied health practitioners (such as physician assistants and nurse practitioners) may participate in the patient's care.

2. TEACHING INSTITUTION. SHC is a teaching facility, training physicians, surgeons, nurses and other health care personnel. At the request, and under the supervision, of the attending physician, I agree that residents, interns, medical students, post-graduate fellows, visiting faculty members and other health care personnel in training may participate in the care of the patient. Certain medical services may be provided by individuals who do not have a physician's certificate but are qualified to participate in a special program as a visiting faculty member.

3. PHOTOGRAPHY. I consent to the taking of pictures, ***videos***, or other electronic reproductions of the patient, including of their medical or surgical condition or treatment, and the use of the pictures, ***videos*** or electronic reproductions for purposes permitted by law. ***I consent to the evaluation and examination by a physician or other health team professionals who may be physically distant from me via virtual technologies, including but not limited to two-way video, digital images, and other virtual technologies as determined by my providers. I understand that my digital images in any form may be used for Stanford Medicine purposes, such as treatment, quality improvement, patient safety, education and security.*** Under specific circumstances and as required by law, I may be asked for a separate consent prior to the taking of pictures, videos or other electronic reproductions and the use or disclosure of those pictures, videos, or electronic reproductions. If the image is being used for research purposes and could be directly used to identify the patient, I will be asked for authorization to use or disclose the image as required by law.
I understand that under California law I may not photograph, film or record any image of or conversation with a SHC employee or physician or another SHC patient without the explicit consent of all parties involved and that violation of this law may result in criminal or civil liability

4. JOINT INFORMATION. I understand that patient information and records may be shared between SHC and the Lucile Salter Packard Children's Hospital at Stanford to facilitate patient care.

EMERGENCY PATIENTS ONLY

Agreement to paragraphs 1, 2, 3, and 4: _____ _____ _____

(BEFORE SCREENING EXAM) Patient or Responsible Person Signature Date Time

5. FINANCIAL AGREEMENT. For the services to be rendered (e.g., hospital, physician), I agree to accept full financial responsibility for the patient's account in accordance with the regular rates and terms of SHC. This includes financial responsibility for all deductibles and co-payments that may be required by the patient's insurance or health plan, including Medicare and Medi-Cal. Should the patient's account(s) be referred to an attorney or a collection agency for collection, I further agree to pay actual attorneys' fees and lawsuit-related expenses incurred in addition to other amounts due. When the services are to be billed to insurance, a health plan or another payment source, paragraphs 6 (Contracted Health Plan Patients and Other Sources) and/or 7 (Assignment of Insurance Benefits) will also apply.

6. CONTRACTED HEALTH PLAN PATIENTS AND OTHER SOURCES. I understand that the patient may be eligible for certain health care coverage through a health plan (HMO, PPO) on the list of health plans with which SHC contracts, or through some other source (e.g., clinical trial sponsor, employer's workers' compensation insurance). I agree to be responsible under paragraph 5 (Financial Agreement) for paying the patient's account: (a) if SHC does not contract with the health plan; (b) for any co-payment and deductible; (c) for services not approved by the health plan or other

source; or (d) for services not covered and/or paid for by the patient's health plan or other source to the extent allowed by law or contract.

7. ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE BENEFITS). I authorize direct payment to SHC of any insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for outpatient services, including emergency services if rendered, at a rate not to exceed the actual institutional and professional charges. I understand and agree that I am financially responsible under paragraph 5 (Financial Agreement) for charges not paid in accordance with this assignment. If applicable, I further attest that information given to SHC to assist the patient in applying for payment under Medicare or Medi-Cal is correct.

8. DISCHARGE TIME. Discharge time for inpatients is 11:00 a.m. If, due to the fault of the patient or the undersigned, discharge occurs after 11:00 a.m., the patient's account may be charged for an additional day.

9. NURSING CARE (INPATIENTS). SHC provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. I understand that if the patient desires the services of a private or special duty nurse, I must arrange for this service. SHC shall not be responsible for failure to provide a private or special duty nurse and will not assume any liability arising from the fact that the patient is not provided with such additional care.

10. LEGAL RELATIONSHIP BETWEEN SHC AND PHYSICIANS. Except for those physicians under contract with SHC, such as faculty physicians practicing in the Stanford Clinics, all physicians and surgeons furnishing services to the patient are independent contractors with the patient and are not employees or agents of SHC. I understand that the patient is under the care and supervision of his or her attending physician and that it is the responsibility of SHC and its non-physician health care staff to carry out the instructions of such physician or surgeon.

11. PERSONAL VALUABLES. SHC maintains a fireproof safe for safekeeping of valuables. SHC shall not be liable for the loss or damage to any personal property, unless deposited with SHC in the safe. I understand that the liability of SHC for loss of any personal property that is deposited with SHC in the safe is limited by statute to five hundred dollars ($500.00).

The undersigned certifies that he/she has read <u>both</u> pages of the Terms and Conditions of Service, has received a copy of it, and is the patient or is duly authorized by or on behalf of the patient to execute and accept its terms.

_____ _____ _____
Patient or Responsible Person Signature Date Time

_____ _____
Print Name Witness

Please indicate relationship of person signing this document:

☐ Patient Authorized to Consent ☐ Parent with Legal Custody

☐ Legal Guardian/Temporary Legal Guardian

Explain type of guardianship _____

☐ Official documentation of guardianship (e.g., court papers) received

☐ Person with Written Authorization (e.g., Caregiver's Authorization Affidavit, Third Party Authorization, Durable Power of Attorney)

Explain type of written authorization _____

☐ Documentation of written authorization received

IF INTERPRETED: _____ _____ _____ _____
Interpreter Signature Print Name Date Time

_____ _____
Position/Relationship to Patient Language

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept full financial responsibility for services rendered to the patient and to accept the terms of the paragraphs on Financial Agreement (5), and, if applicable, Contracted Health Plan and Other Sources (6) and Assignment of Insurance Benefits (7) above.

_____	_____	_____	_____	_____
Financially Responsible Party	Relationship to Patient	Date	Time	Witness

Please see the notice on Release of Information on the back of this page

RELEASE OF INFORMATION

Stanford Health Care may release basic information about the patient to members of the general public, but only upon receipt of an inquiry that specifically contains the patient's name, and if the patient has not requested that the information be withheld. This basic information includes the patient's general condition and location in the hospital unless the patient is being treated for certain conditions. **If you do not want such information to be released, you must make a written request that this information be withheld for each inpatient stay;** the appropriate forms can be obtained from Patient Admitting Services.

In compliance with the federal privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA), Stanford Health Care provides patients with its ***Notice of Privacy Practices,*** which describes how medical information about patients may be used and disclosed, and how patients can access this information. Copies of the *Notice of Privacy Practices* are available at any registration desk, on our website at www.stanfordhealthcare.org in the Patients and Visitors section under Patient Privacy, or by calling the Stanford Health Care' Privacy Office at 650-724-4722.

FINANCIAL ASSISTANCE AVAILABLE

Stanford Health Care has a variety of financial assistance options available to patients who are uninsured or underinsured. **Stanford Health Care will assist patients in determining if they qualify for financial assistance or if there are programs available that may help pay for medical services.** Additional information and/or a statement of charges for services provided by Stanford Health Care can be obtained by contacting the Customer Service Unit of Patient Financial Services at 800-549-3720.

Financial assistance applications are available at all Stanford clinics and hospital registration areas. The application can also be found on our website at www.stanfordhealthcare.org in the Patients and Visitors section under Financial and Insurance Information or by calling the customer service number above. Applications are reviewed to determine what assistance may be available; applicants are notified of the outcome of this review within 10 business days after the completed and signed application is received.

Patients who qualify may receive assistance with bills for services provided by Stanford Health Care and by physicians employed by Stanford University. Services may include inpatient and outpatient care, emergency services, co-payments and deductibles, non-covered charges, denied days and stays, and other special circumstances. Patients who have no insurance or inadequate insurance and meet certain low- and moderate- income requirements may qualify for discounted payment or charity care.