



CEDARS-SINAI MEDICAL CENTER

## CONDITIONS OF ADMISSIONS

PATIENT I.D.

***The above-named Patient is admitted to Cedars-Sinai Medical Center (“Hospital”) for inpatient, outpatient and / or emergency treatment subject to the following terms and conditions:***

### **1. CONSENT TO MEDICAL AND SURGICAL PROCEDURES**

The undersigned consents to the procedures that 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 provided to the Patient under the general and special instructions of the Patient’s physician or surgeon.

### **2. NURSING CARE**

The Hospital provides only general duty nursing care unless, upon orders of the Patient’s physician, the Patient is provided more intensive nursing care. If the Patient’s condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged 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 the Patient is not provided with such additional care.

### **3. PHYSICIANS ARE INDEPENDENT CONTRACTORS**

All physicians and surgeons furnishing services to the Patient, such as radiologists, pathologists, anesthesiologists and the like, are independent contractors and are ***not*** employees or agents of the Hospital. These physicians may bill separately for their services.

**Patient initials:** \_\_\_\_\_

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, to 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.

### **4. PERSONAL BELONGINGS**

It is understood and agreed that the Hospital maintains a fireproof safe for the safekeeping of money and valuables, and the Hospital shall not be liable for the loss or damage to any money, jewelry, documents, furs, fur coats and fur garments or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss or damage to any other personal property, unless deposited with the Hospital for safekeeping. The liability of the Hospital for loss of any personal property which is deposited with the Hospital for safekeeping is limited by statute to five hundred dollars (\$500.00) unless a written receipt for a greater amount has been obtained from the Hospital by the Patient.



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### 5. TEACHING HOSPITAL

Patient acknowledges that the Hospital is a teaching hospital and as such the training of physicians and surgeons, nurses and other health care personnel takes place at the Hospital. Patient understands that nurses, physicians and other health care personnel in training may participate in the operation or special diagnostic or therapeutic procedures specified above under a supervising physician or surgeon, and Patient hereby consents thereto.

### 6. CONSENT TO PHOTOGRAPH

The taking of still or moving pictures involving Patient medical or surgical procedures or to document a physical condition, or for scientific, educational, or research purposes, is hereby approved and consented to by the Patient, provided that the Patient is not specifically identified whether by writing or depiction unless the photograph is to be part of the medical record for treatment purposes.

### 7. 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 of the Hospital in accordance with the regular rates and terms of the Hospital, including its financial assistance policies. 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.

### 8. 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.

### 9. HEALTH PLAN (INSURANCE) OBLIGATION

The Hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the Admission or Registration offices. The Hospital has no contract, express or implied, with any plan that does not appear on the list. It is the Patient's obligation to assure that the Patient's health plan has authorized the services to be provided by the Hospital. The undersigned agrees that he / she is individually obligated to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital, including its financial assistance policies, if he / she belongs to a plan which does not appear on the above-mentioned list or if the Patient fails to obtain the health plan's authorization.



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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.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ A.M./P.M.

Signature: \_\_\_\_\_
(Patient / parent / conservator / guardian)

If signed by other than Patient, indicate relationship: \_\_\_\_\_

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

I agree to accept financial responsibility for services rendered to the Patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above.

Financial Responsibility Agreement by Person Other Than the Patient or the Patient's Legal Representative

Date: \_\_\_\_\_ Time: \_\_\_\_\_ A.M./P.M.

Signature: \_\_\_\_\_
(financially responsible party)

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

A COPY OF THIS DOCUMENT SHOULD BE GIVEN TO THE PATIENT AND ANY OTHER PERSON WHO SIGNS THIS DOCUMENT