CONDITIONS OF ADMISSION AND TREATMENT

I, PATNAME, am presenting myself or minor dependent to Pinckneyville Community Hospital for medical and/ or surgical care.

1. **Consent for Treatment**: I consent to the providing of medical and/or surgical care by my physician, consulting physicians, and other health care provider including, but not limited to diagnostic and therapeutic tests and procedures and treatment as may be ordered by my physician, and/or his/her designees including consulting physicians. This consent includes but is not limited to the performance of invasive diagnostic procedures, administration of fluids, medications and any radiology procedures.

2. **Emergency Room Services**: Pinckneyville Community Hospital will not deny emergency room services to a person who needs them but cannot pay for them.

3. **Patient Rights & Responsibilities**: Pinckneyville Community Hospital provides a copy of the Patient Rights & Responsibilities to patients in the inpatient and swing bed admission packet. Signature on this consent form serves as acknowledgement of patient receipt. The Patient Rights & Responsibilities are also posted on the Hospital's website at www.pvillehosp.org.

4. **Blood Products:** This consent includes administration of blood and/or blood products/components if required. **By initialing here _____, I do not consent to, and opt out of, administration of blood and/or blood products/components.**

5. **Valuables/Personal Items:** I agree to deposit money, jewelry, and other valuables with Hospital for safekeeping, or to send them home. If I choose to keep any such valuables or any personal items such as dentures, eyeglasses, contact lenses, etc., I assume responsibility for them.

6. **Insurance Coverage & Financial Responsibility:** I authorize my insurance company or organization to pay benefits directly to the Hospital, this being my assignment of benefits to said corporation. I do hereby authorize the CFO of Hospital to endorse for me any checks made payable to me for benefits or claims collected on this assignment and to apply any credit balance to any other account I may owe said Hospital. I understand that I am obligated to promptly respond to any insurance company inquires for additional information in order to process my claim. I also understand that it is my responsibility as the patient to know and understand my insurance benefits including any coverage limits. I understand that all patient portion amounts, including non-covered services, are due upon request and are payable to Pinckneyville Community Hospital. I further agree to pay any additional charges, not to exceed 25% of the balance due, in the event that I would fail to pay my bill, in addition to potential interest on outstanding balances of up to 12% per annum, and hereby give authorization to Hospital to verify employment and credit history report on myself or responsible guarantor as part of those reasonable collection efforts.

7. **Phone Number Usage Consent**: For us to service your account or to collect any amounts you may owe, you agree the Hospital, including its collection agency and legal counsel, may contact you or your spouse by telephone at any telephone number associated with your account, including wireless (cellular) telephone numbers which could result in charges to you, as well as telephone numbers of guarantors, insurance subscribers and emergency contacts listed on your account. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable. **Initials: _____**

8. **For Medicare/Medicaid Beneficiaries Only:** I certify that the information given by me in applying for payment under Titles XVIII & XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished me by, or in Pinckneyville Community Hospital, including physician services. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information necessary to determine these benefits or related services.

9. **Statement of Non-Discrimination:** Pinckneyville Community Hospital and Family Medical Center do not discriminate against any person on the basis of race, color, sex, national origin, disability (physical or mental), religion, age, sexual orientation, gender identity, sex stereotyping, pregnancy or status as a parent, in admission, treatment, or participation in its programs, services and activities, or in employment.

10. **Photographs**: The undersigned hereby authorizes Pinckneyville Community Hospital to photograph patient for identification and clinical purposes. Photographs for identification and clinical purposes are incorporated as part of the patient's medical record.

11. **Recordings, Film and Other Images**: I authorize and consent to the production or use of recordings, films, or other images of me (i.e. any photographic, video, electronic, or audio media) for purposes of identification, diagnosis or treatment in connection with the care provided to me by my attending physicians(s) or personnel from Pinckneyville Community Hospital, including distant site providers via tele-health technology. I understand recordings, films or other images of me are considered protected health information (PHI) with the same protections as the patient's medical record and further consent to the use of my PHI for internal educational, training, performance improvement, and patient safety purposes at Pinckneyville Community Hospital. I am not providing my consent to the use of recordings, films or other images of me for external use (i.e. those that may be intended to be heard or seen by the public), and understand that a separate consent must be obtained from me before any such use occurs.

12. **Release of Information:** I authorize Pinckneyville Community Hospital to disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract with Pinckneyville Community Hospital or the patient for charges. This release includes the diagnosis, treatment and/or hospitalization for mental health, alcohol and/or drug abuse. *This release also includes the results of any blood test performed to determine the presence of the HIV virus (causative agent of AIDS), and/or the diagnosis and/or treatment of AIDS.* In addition, I authorize any health care provider, including any physicians and facilities to which the patient may be transferred, to provide information to Pinckneyville Community Hospital or its designee upon request, concerning the patient's care, condition, and treatment, for quality improvement or risk management purposes. I further authorize Pinckneyville Community Hospital to give verbal and/or written information to agencies or physicians continuing medical care to the patient following transfer to discharge from any Pinckneyville Community Hospital service.

13. **Patient Directory**: I have been informed that it is customary for the Hospital to have a Patient Directory for use by staff to inform visitors inquiring as to my location and general condition and for use by local clergy. I understand that it is not Hospital policy to share patient names with news media. However, if the news media asks about me by name, Hospital policy allows release of my general condition. By signing below, I hereby give consent for my name to be listed in the Hospital's Patient Directory. I may elect to opt out of this directory entirely by marking the following box; however, this would also preclude the Hospital from sharing my location with family and friends visiting the Hospital.
    ☐ I do not consent to the listing of my name on the Hospital Patient Directory. Partial Restrictive Options: ☐ I do not consent for my name to be released to the clergy. ☐ I do not consent to information being released to news media, even if they ask about me by name.

14. **Patient Portal:** I understand that I have the option to provide Pinckneyville Community Hospital with an email address permitting an email invitation to the Patient Portal upon inpatient discharge. I also understand that by providing an email address, I am consenting and understand that once information has been processed through secure electronic portals by me, I am responsible for the Confidentiality and Security of said information.

15. **Students**: Pinckneyville Community Hospital cooperates with colleges/universities to provide clinical experience to students. As a result, students may be observing and participating in patient care.

16. **Privacy Notice, Patient Bill of Rights and Understanding Balances Due Brochure:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our privacy notice before signing this consent. The Patient Bill of Rights provides patients with information on how you can reasonably expect to be treated during the course of your hospital stay and treatment. The Hospital also provides information on Understanding Balances Due For Services, Billing & Collection Procedures and Your Payment Options. By signing this form, you acknowledge that we have notified you of this information posted in our facility, on the hospital website or provided in your admission packet when applicable, and have provided a copy upon request. By initialing here, you have acknowledged we have informed you of these documents and have offered printed copies.

    Initials: _____

17. **Notice of Independent Practitioners:** Practitioners (physicians and other providers) on staff at this Hospital, including, but not limited to, emergency physicians, pathologists, radiologists, CRNA or other anesthesiology providers and other Hospital based physicians, advance practice professionals, my attending physician and consulting physicians are NOT employees or agents of the Hospital, with the exception of certain non-specialty Family Medical Center practitioners. All such practitioners are independent contractors, not employed by the Hospital, who have been granted the privilege of using this facility for the care and treatment of their patients. I recognize that these practitioners exercise their own independent medical judgment and they are not subject to the supervision or control of the Hospital with respect to my treatment. Hospital and Family Medical Center may have arrangements where they bill on behalf of the independent practitioners; however, given the independent status of these practitioners, this billing is done as a courtesy for or on behalf of the practitioner.

    I acknowledge that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of Pinckneyville Community Hospital for my care.

    Initials: _____

I certify that I have read and received a copy of the foregoing as the patient or as a duly authorized representative of the patient as the patient's general agent to execute the above and accept its terms.

PATADMIT _____
Date Time

_____ _____
Patient or Patient's Agent or Representative Indicate Relationship

Verbal Consent or Patient unable to sign due to: _____

1st Witness Signature & Title _____

2nd Witness Signature & Title _____

Nondiscrimination Notice

Pinckneyville Community Hospital and Family Medical Center complies with applicable Federal civil rights laws and do not discriminate against any person on the basis of race, color, sex, national origin, disability (physical or mental), religion, age, sexual orientation, gender identity, sex stereotyping, pregnancy or status as a parent, in admission, treatment, or participation in its programs, services and activities, or in employment.

Pinckneyville Community Hospital:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats) or vision assistance aides (reading glasses or magnifying glasses/sheets)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services contact any employee, or Pinckneyville Community Hospital Administration, at phone number 618-357-5904.

If you believe that Pinckneyville Community Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Quality/Risk Manager, P.O. Box 437, Pinckneyville, IL 62274, Phone: 618-357-5976, Fax: 618-357-8888, or Email at riskmgr@pvillehosp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Quality/Risk Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Limited English Proficiency Taglines

As required to meet compliance with Section 1557 of the Affordable Care Act (ACA)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-618-357-2187 (TTY: 7-1-1).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-618-357-2187 (TTY: 7-1-1).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-618-357-2187 (TTY: 7-1-1).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-618-357-2187 (TTY：7-1-1）。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-618-357-2187 (TTY: 7-1-1)번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-618-357-2187 (TTY: 7-1-1).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-618-357-2187 (رقم هاتف الصم والبكم: 7-1-1).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-618-357-2187 (телетайп: 7-1-1).

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خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-618-357-2187(TTY: 7-1-1).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-618-357-2187 (TTY: 7-1-1).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-618-357-2187 (TTY: 7-1-1).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-618-357-2187 (TTY: 7-1-1) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-618-357-2187 (ATS : 7-1-1).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-618-357-2187 (TTY: 7-1-1).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-618-357-2187 (TTY: 7-1-1).