MEMORIAL HEALTH SYSTEM

COMMUNITY • HEALTH • EXCELLENCE • LIFE

MEMORIAL HEALTH SYSTEM
CONDITIONS OF ADMISSION

Marietta Memorial and Selby General Hospitals and Clinics shall be referred to as the "Hospital" in this document

1. Nondiscrimination Statement: Memorial Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or gender identity and transgender.

2. Language and Hearing Impaired Assistance: ATTENTION: If you speak Spanish or Chinese, or have a disability that impairs your ability to communicate effectively, language assistance services, free of charge, are available to you. Call 740-374-1436. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a 740-374-1436. 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 740-374-1436 。

3. Physicians are Independent Contractors: The patient is under the control, direction, and treatment of his or her attending physician. The undersigned understands that he/she may require the service of physicians or groups of physicians who are not Hospital agents or employees, including Pathologist(s) and Radiologist(s) or other professional(s) or supplier(s) of services. The Hospital is not responsible for the acts or omissions of physicians that are not directed or controlled by the Hospital.

4. Medical and Surgical Consent: The undersigned consents to any imaging examination (including X-ray, MRI, CT), laboratory procedures, medications, infusions, transfusions of blood or blood products, anesthesia, medical or surgical treatment, general nursing care and/or other services rendered to the patient by members of the medical or allied health staff and Hospital employees under the instructions of treating physicians, physician assistants and nurse practitioners.

5. Electronic Information Consent: The undersigned consents to the access, downloading and use of electronic health information, including electronic prescription information, for treatment and payment purposes; and the taking and use of the undersigned's electronic photo solely for Hospital registration and identification purposes.

6. Health Information Exchange: MHS participates in one or more Health Information Exchanges. Healthcare providers can use these electronic networks to securely provide access to your health records so your providers have an accurate understanding of your health needs. I hereby authorize MHS to allow access to my health information through the Health Information Exchange for treatment and other health care operations. I understand that I may opt-out at any time by notifying the MHS Information Management Services/Medical Records Department.

7. Personal Belongings: It is understood and agreed that the Hospital maintains a safe for money and valuables, and the Hospital will not be liable for the loss or damage to any money or property of the patient unless placed in the safe.

8. Access to Patient Room and Other Areas of the Hospital. It is understood and agreed that the Hospital has the right to control access to patient rooms, to confiscate any illegal or unauthorized drugs, weapons, or other contraband that may be found, and to conduct electronic and other surveillance in all areas of the Hospital, including but not limited to patient rooms, for purposes of security, patient care, quality improvement, peer review, and other Hospital needs.

9. Financial Agreement and Payment Guarantee. The patient and/or undersigned agree that in consideration of the services to be rendered to the patient, they hereby jointly and individually obligate themselves to pay the charges incurred in accordance with the rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate.

10. Service Notifications, Surveys and Collection of Amounts Owed. The patient and/or undersigned agree, in order for the hospital to communicate with you regarding service notifications, surveys and collections of amounts owed, we may contact you using pre-recorded/artificial voice and electronic messages by: (i) telephone, *including wireless telephone numbers*; (ii) text messages; and (iii) e-mail, which could result in charges to you. You may notify us any time that you do not wish to be contacted in this manner and we will respect your choice.

11. Assignment of Insurance and Benefit Rights: In the event the undersigned is entitled to Hospital medical benefits, of any type whatsoever, arising out of any policy of insurance which insures patient or any other party liable to patient, the rights and benefits of such policy are hereby assigned to the Hospital as the undersigned's duly authorized representative for: i) application on patient's bill and receipt of full payment under the policy; ii) initiation, pursuit, and prosecution of administrative appeal remedies and all other legal and equitable remedies with any said insurers or providers of Hospital benefits; and iii) obtaining a copy of the insuring agreement, governing plan, summary document, and settlement information; and iv) obtaining a copy of any necessary medical information from providers. Additionally, this assignment is effective for

applications where the patient may be eligible for reimbursement for certain medications or devices through the medication or device manufacturer. The undersigned authorizes the use of the signature below on all insurance and/or employee health benefits claims and appeal submissions, and for medication/device manufacturer reimbursement applications. The patient and/or undersigned understand and agree that Hospital may or may not pursue any policy of insurance or medication/device manufacturer reimbursement, within its sole discretion resulting in patient and/or undersigned's responsibility for all or some of the charges. A photocopy of this assignment is to be considered as valid as the original.

12. Tissue Disposal: The undersigned consents to the disposal of any body tissues or parts which may be removed.

13. Nursing Care: This Hospital provides only general-duty nursing care unless, upon orders of the patient's physician, physician assistant or nurse practitioner, the patient is provided more intensive nursing care. If the patient requires the service of a special-duty nurse, it is agreed that those services must be arranged by the patient and/or the undersigned. The Hospital shall not be responsible for the failure to provide the same and is hereby released from liability arising from the fact that the patient receives no such additional care.

14. Consent to Personal Jurisdiction: The undersigned and/or patient expressly agrees that jurisdiction and venue for any lawsuit, proceeding or other action related to any medical, legal, equitable, or other claim or dispute arising out of items, and/or services furnished to the patient by, or at the request of the Hospital, its physicians, contractors and employees, shall be exclusively in a court located in Washington County Ohio where services are rendered. The undersigned and/or patient consents to the transfer and removal of any claim or action brought by patient against Hospital and/or person furnishing services to the patient, to a court in Washington County Ohio. The undersigned and/or patient expressly agrees to the application of Ohio law in any legal action brought on his/her behalf.

THE UNDERSIGNED CERTIFIES THAT HE/SHE: (i) HAS READ, OR HAS BEEN READ THE FOREGOING; (ii) HAS BEEN OFFERED A COPY IT; (iii) IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT; (iv) ACCEPTS THE ABOVE CONDITIONS OF ADMISSION, AND (v) UNDERSTANDS THIS CONDITIONS OF ADMISSION SHALL BE EFFECTIVE FROM THE DATE BELOW UNTIL A NEW CONDITIONS OF ADMISSION IS SIGNED.

_____	_____	_____
Patient or Guarantor	Name Printed	Date