



0541

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 rendered the patient under the general and special instructions of the patient’s physician.

2. Teaching Program:

It is understood that Loma Linda University Medical Center (LLUMC) is a teaching institution and patients participate in medical education programs.

3. Nursing Care:

LLUMC 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. LLUMC 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.

4. Physicians are Independent Contractors:

All physicians furnishing services to the patient, including the radiologist, pathologist, anesthesiologist and the like, are independent contractors and are *not* employees or agents of LLUMC. These physicians will 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 LLUMC and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient’s physician to obtain the patient’s informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instruction of the physician.

5. Personal Belongings:

It is understood and agreed that LLUMC maintains a safe for the safe-keeping of money and valuables. LLUMC shall not be liable for the loss or damage to any money and/or valuables unless deposited with LLUMC for safe-keeping. LLUMC’s safe is not available to patients receiving outpatient services.

6. 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 LLUMC in accordance with the regular rates and terms of LLUMC. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney’s fees, costs and/ or collection expenses. All delinquent accounts shall bear interest at the legal rate.

7. Law Enforcement Agency Patient Authorization for Release of Information

The undersigned authorizes LLUMC to inspect and/or receive copies of law enforcement reports related to or arising out of any accident or injury leading to the patient’s admission to or treatment at LLUMC.



LOMA LINDA UNIVERSITY
MEDICAL CENTER

CONDITIONS OF TREATMENT

Original – Medical Records

Copy – Patient

PATIENT IDENTIFICATION

Name:

Birthdate:

Medical Record #:

8. Assignment of Insurance Benefits:

The undersigned authorizes, whether he/she signs as agent or patient, direct payment to LLUMC 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 LLUMC’s actual charges. It is agreed that payment to LLUMC, pursuant to this authorization, by an insurance company/ third party payer shall discharge said insurance company/third party payer 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. For Medicare Beneficiaries, the undersigned certifies that the information given herein in order to apply for payment under Title XVIII of the Social Security Act is correct.

9. Health Plan Obligation:

LLUMC maintains a list of health plans with which it contracts. A list of such plans is available upon request. LLUMC has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by LLUMC if he/she belongs to a plan which does not appear on the above mentioned list.

10. Confidential Treatment of All Communications/Release of Medical Records & Billing Information

It is understood and agreed that all communications and records pertaining to the patient’s care and stay in LLUMC will be held confidential. The undersigned acknowledges that he/she received a separate “Notice of Privacy Practices” (“NPP”) that explains the patient’s rights in detail and how LLUMC may use and disclose the patient’s protected health information. The undersigned specifically authorizes the use and disclosure of all medical record and billing information in accordance with the NPP.

11. Photographic Consent

The undersigned, consent to the taking of pictures of the patient’s surgical condition or treatment and the use of the pictures, for purposes of the patient’s diagnosis or treatment or for the hospital’s operations, including peer review and education or training programs conducted by the hospital.

The undersigned certifies that he/she has read the forgoing, 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. This Condition of Treatment shall be valid for all present and future inpatient and outpatient services rendered to the patient by LLUMC and shall remain in effect until revoked or replaced in writing.

Signature _____ Date _____ Time _____
(patient / parent / conservator / guardian)

If signed by other than patient, indicate relationship: _____

Witness: _____

Person authorized to receive billing information: _____

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

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.

Signature _____ Date _____ Time _____
(financially responsible party)

Witness: _____



LOMA LINDA UNIVERSITY

MEDICAL CENTER

CONDITIONS OF TREATMENT

Original – Medical Records

Copy – Patient

19-0541 (1-08)

PATIENT IDENTIFICATION

Name: _____

Birthdate: _____

Medical Record #: _____