# Conditions of Admission, Consent for Inpatient/Outpatient Care and Independent Practitioner and Independent Contractor Disclosure

In this document Sparta Community Hospital District means Sparta Community Hospital District and its affiliated entities, including, but not limited to: Sparta Community Hospital, Sparta Community Hospital Quality Healthcare Clinics, and At-Home Healthcare of Sparta Community Hospital (referred to collectively as the "Facility").

Thank you for choosing the Facility for your healthcare needs. In consideration of the services provided by the Facility, you authorize the Facility, either on behalf of yourself or the person for whom you are acting on behalf of, to provide you medical care, share your health information, and receive payment for the services provided. The below consents are applicable to all inpatient and outpatient hospital-based services, as well as all ambulatory and physician office-based services. *Please read carefully. Do not sign this form without reading and understanding its contents.*

## I. DISCLOSURE OF PHYSICIAN AND PROVIDER EMPLOYMENT STATUS

The physicians and other healthcare providers participating in your medical care at the Facility are either employed by Sparta Community Hospital District or are non-employed independent practitioners or contractors.

### A. Notice of Non-Employed Independent Practitioners and Contractors

You may receive medical services from physicians and other healthcare providers who are NOT employees or agents of Sparta Community Hospital District, but instead are independent practitioners or contractors that have been granted privileges to use Sparta Community Hospital District's facilities to provide care and treatment to their patients.

Independent practitioners and contractors who participate in your care at Sparta Community Hospital District include, but are not limited to emergency physicians, pathologists, radiologists, anesthesia providers, hospitalists, and surgeons. These independent practitioners and contractors are NOT employed by Sparta Community Hospital District.

### B. Notice of Employed Physicians and Providers

Only the physicians and healthcare providers listed below are employed by Sparta Community Hospital District:

| | | |
|---|---|---|
| Russell Coulter, MD | Karen Chamness, PA-C | Abby Woods, APRN |
| David Chung, MD | Deanne Rieckenberg, APRN | Danielle Preuss, PA-C |
| Elvira Salarda, MD | Nickie Murphy, APRN | Jennifer Demsar, APRN |
| Amy Eppstein, MD | Ashley Hundelt, APRN | Destiny Wilson, APRN |
| Mark Preuss, MD | Jennifer Watson, APRN | Victoria Koch, APRN |
| Shawn Beckemeyer, MD | Danielle Scott, PA-C | Tyler Tanzyus, APRN |
| Franklin James, MD | Tiffany Hostert, APRN | Jordan Priebe, APRN |
| Kelly Wood, MD | Ashley Friederich, APRN | Helaine Blomenkamp, APRN |
| Maxwell Hayden, DPM | Carrie Lutman, APRN | |

**I confirm that I acknowledge and understand that if my physician or other healthcare provider is NOT listed above, then he or she is NOT an agent or an employee of Sparta Community Hospital District. I have read and understand that Sparta Community Hospital District uses non-employed independent practitioners and contractors to provide various medical services. My decision to seek care at Sparta Community Hospital District is not based upon any understanding or representation that the physicians or other healthcare providers who will be treating me are agents or employees of Sparta Community Hospital District. I acknowledge that any questions about this Disclosure of Physician and Provider Employment Status and the important information contained in it have been answered to my satisfaction.**

Patient initials__________

## II. GENERAL CONSENTS AND ACKNOWLEDGMENTS

The Facility uses both employed and non-employed physicians and non-physician practitioners (referred to individually each, and collectively all, the "Provider(s)").

**A.** **Consent for Treatment**: I acknowledge that I seek treatment at the Facility. I consent and authorize the Facility, the Provider(s), and ancillary medical personnel to provide treatment as my attending Provider(s) or others working under the general and/or special instructions of my Provider(s) consider necessary. I understand treatment includes, but is not limited to, routine nursing care, physical examinations, routine diagnostic and therapeutic tests and procedures, including invasive diagnostic procedures, administration of fluids, blood, blood products, and medications. I understand that if, after consenting to treatment, I leave the Facility without the approval of my treating Provider(s), I will relieve the Facility and the Provider(s) of all responsibility for my actions.

**B.** **Patient Complaints**: I understand I have a right to express a concern or grievance about any quality-of-care issue by using the patient grievance (complaint) resolution process established by the Facility. I understand I can contact the Patient Relations Quality Coordinator for assistance.

**C.** **Training**: I understand that the Facility has educational programs and affiliations with academic institutions, and I agree to student and resident participation in my care under appropriate supervision. I understand that I have the right to tell my Provider(s) or care team if I do not want these individuals involved in my care for training and education.

**D.** **Photography and Recordings**: I understand the Facility may take photographs, video, and/or audio monitoring/recording of me for purposes of identification, diagnosis, patient care, security or for the purposes of healthcare operations, such as quality improvement or risk management activities. I understand that these images and/or recordings may be permanently retained in my medical record. I understand that these images and/or recordings will be securely stored and protected. I understand that photography for other purposes (e.g., marketing or public relations) requires separate consent.

I understand that I am not allowed to take pictures or make video or audio recordings of my care or treatment or healthcare providers. I understand that I am also not allowed to take pictures or record other patients while receiving medical care or while on the Facility's property.

I understand the Facility may use surveillance equipment in non-private places (e.g., entrances, walkways, parking lots and work areas) for internal and external hospital security monitoring to provide added security. I understand that my privacy will be maintained within the use of this material.

**E.** **Consent to Email and/or Text Usage**: I agree that all email addresses and telephone numbers (including cellular) I provide to the Facility may be used by the Facility to communicate with me by email or text messaging for healthcare communications. I understand electronic communications are not confidential or secure methods of communication. I further understand that, because of this, there is no assurance of confidentiality of information communicated in this manner. The Facility does not charge for this service, but standard text messaging and data rates may apply.

**F.** **Personal Valuables**: If I retain any valuables, such as money, jewelry, personal electronics, dentures, eyeglasses, hearing aids, prosthetics, or other articles, goods, or property of any value, instead of sending them home or placing them in safekeeping with the Facility, I understand the Facility is not responsible for the loss or damage to any personal property kept by me. I acknowledge that the Facility recommends that I do not bring or keep valuables with me during my time at the Facility.

**G.** **Telehealth Services**: I understand the Facility may provide certain services by remote telehealth technology. I understand that there are benefits to utilizing telehealth services, which include, but are not limited to, convenient medical evaluation and management. I also understand that there are risks involved in receiving treatment through

telehealth, which will be explained to me before receiving treatment. I understand I can refuse telehealth services without affecting my right to future care or treatment.

**I have read and understand the General Consents and Acknowledgment provision and agree to its terms and conditions**.

Patient initials__________

## III. HEALTH INFORMATION CONSENTS AND ACKNOWLEDGMENTS

A. **Notice of Privacy Practices Acknowledgment**: I understand the Facility's Notice of Privacy Practices provides information about how my health information may be used and disclosed and describes my rights concerning my health information. I understand that I have a right to receive a paper copy of the Notice of Privacy Practices or that I may review an electronic copy on the Facility's website at www.spartahospital.com.

B. **Patient Rights and Responsibilities Acknowledgment**: I understand the Patient Rights and Responsibilities provides important information about my rights and responsibilities as a patient at the Facility, including a description of the Facility's procedures for resolution of any complaints. I understand the Patient Rights and Responsibilities notice is posted on the Facility's website, and I can request a paper copy at any time.

C. **Consent for Use and Release of Information**: I give permission to the Facility, including its treating and referring providers and other staff members, to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to healthcare providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); or (3) for the healthcare operations of the Facility or another healthcare provider that has had a relationship with me (quality assessment, training programs, planning, and fundraising). I understand the Facility may also release my health information as required by law or court order. For more detailed information about the way my information may be used or released, I can read the Facility's Notice of Privacy Practices. I understand medical records released may include HIV/AIDS information, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

   I understand I can cancel this authorization at any time by giving written notice to the Health Information Management department. I understand any uses or disclosures already made with my permission cannot be undone.

D. **External Prescriptions**: I consent and authorize the Facility and the Provider(s) or other prescribers providing treatment to me, to access or input prescription benefit or medication history for me, on the Surescripts Network or other electronic prescription services.

**I have read and understand the Health Information Consents and Acknowledgment provision and agree to its terms and conditions**.

Patient initials__________

## IV. FINANCIAL CONSENTS AND ACKNOWLEDGMENTS

A. **Financial Agreement**: I understand that I am obligated to pay the Facility's usual and customary charges for all services received by me at the Facility. I understand that it is my responsibility to check with my insurance carrier to determine if the services provided to me at the Facility are covered. I understand I am financially responsible for payment of any amounts not covered by insurance. If my account becomes delinquent and is referred to an attorney or a collection agency, I will be expected to pay attorneys' fees, court costs, and collection expenses. I understand that I am responsible for any non-covered services, deductibles, and co-payments. If I receive payment directly for the charges associated with my treatment, I acknowledge it is my responsibility to pay any such payments to the Facility.

B. **Uninsured/Self-Pay Patients**: I understand that if I do not have health insurance or if I choose not to use my health insurance benefits, I may be responsible for all charges incurred at time of service. I understand I can contact the Patient Financial Services department for further information

C. **Physician Services & Professional Services Billing**: I understand I may be billed separately for additional professional services performed or supervised by physicians and/or other healthcare professionals who are independent contractors and not employed by Sparta Community Hospital District. I understand I may receive a separate bill from these independent providers for their professional services.

D. **Assignment of Benefits**: I authorize and assign any payment otherwise payable to me from any insurance, health plan or other third-party payer to the Facility and the Provider(s) who provide services, care or treatment to me at or on behalf of the Facility. I acknowledge that I am responsible for providing the Facility with information necessary to allow the Facility to bill my insurance. I understand I am financially responsible for payment of any charges not paid by insurance, health plan or other third-party payer, including if I have no insurance or coverage is denied. I further understand the Facility does not accept responsibility for collecting my insurance claim or negotiating a settlement on a disputed claim, and that I am responsible for the timely payment of my account(s).

E. **Medicare/Medicaid Payment**: I certify that the information given by me in applying for, or assigning, payment under Medicare or Medicaid is correct. I request payment of authorized Medicare or Medicaid benefits be paid to the Facility on my behalf for services provided to me, including physician services. I authorize the Facility and the Provider(s) to release any information about me that is necessary to act on this request for payment.

**I have read and understand the Financial Consents and Acknowledgment provision and agree to its terms and conditions.**

Patient initials__________

## Summary Acknowledgment

I have read, or have had read to me, this document, and I completely understand this document and that I am the patient, or I am duly authorized to execute this acknowledgment on behalf of the patient. I confirm that I have read, understood, and agree to the terms in this Conditions of Admission, Consent and Disclosure. I have had an opportunity to ask questions and have no remaining questions at this time. I understand a copy of this consent and authorization may be used in place of the original. I also acknowledge that I have the right to receive a copy of this consent form upon my request.

_________________________________ _______________ __________________

Patient/Patient Representative Signature Date/Time Witness

v12/30/22