



**CONSENT FOR TREATMENT AND  
CONDITIONS OF ADMISSION**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Account #: \_\_\_\_\_

**Place Patient Label**

This "Consent" form gives permission to the Sparta Community Hospital District d/b/a Sparta Community Hospital ("Sparta Hospital") to provide you medical care, share your health information and receive payment for the services provided. Please ask about any part of this form that is not clear. Be sure you have your questions answered before you sign this form. For this form, Sparta Hospital means any or all Sparta Hospital facilities and patient care locations.

**GENERAL CONSENTS AND ACKNOWLEDGMENTS:**

I consent to diagnostic and treatment procedures, examinations and laboratory procedures, inpatient admission or other services needed for my treatment at Sparta Hospital by physicians and other medical and allied health professionals. I understand that this form authorizes any reasonable medical action taken for any purpose while I receive care at Sparta Hospital. I understand and agree that my care may be provided using telehealth technology. I understand that for services I receive using telehealth technologies I may be in a different location than the provider. I am aware that I might need to sign a different consent form for some kinds of procedures or treatments. I acknowledge that no one has made any guarantees to me about the results of my treatments or procedures. I understand that my care team at Sparta Hospital may include resident physicians and students or other trainees.

I understand, especially in emergency situations, treatment may have been initiated before my ability to review and sign this form. I agree that I have received notice from Sparta Hospital in the document titled "Notice of Non-Employed Independent Physician and Practitioner Services" that there are physicians and other medical practitioners who provide medical services to me at Sparta Hospital who are not employees or agents of Sparta Hospital but are independent contractors or independent practitioners. I acknowledge and understand all terms of this form, including but not limited to the "Notice of Non-Employed Independent Physician and Practitioner Services", are in full effect for the entire duration of my care and treatment at Sparta Hospital. I understand Sparta Hospital does not control or direct the medical decisions made by independent physicians/practitioners. I understand and agree to accept the terms outlined in this form retroactively, even if I had a different assumption or understanding about the employment status of any medical practitioner prior to my review and signing of this form.

If applicable, I have identified my preferred language and whether I require qualified interpreting or other language assistance services during registration. I understand these services are available at no cost and I may request these services at any time during my visit by notifying a member of the patient care team.

I understand that if I wish to provide an advance directive or if I have questions about them, I can inform patient access/registration staff and someone from Sparta Hospital will follow up with me.

I understand photographs and recordings may be taken of me during my care for purposes of identification, diagnosis and treatment. I further understand recordings or photographs that do not include personally identifiable information may be used internally for educational and performance improvement purposes. Unless required by law, the use or release of photographs and recordings for any other purpose requires my express written consent.

I understand that Sparta Hospital may use video monitoring and surveillance equipment for safety and security purposes in both public and non-public areas of Sparta Hospital, including some patient care areas.



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I agree that Sparta Hospital is not responsible for the loss or damage of any money, valuables, and/or personal property that I decide to keep with me while receiving health care services at Sparta Hospital. I agree to release Sparta Hospital from any and all liability from loss or damage of such items.

I understand and agree that my visitors and I must follow all Sparta Hospital facility rules. I understand that words or actions that are disrespectful, discriminatory, hostile or harassing are not tolerated at Sparta Hospital. This includes any form of threatening or aggressive behavior toward Sparta Hospital staff, disrupting another patient's care or experience, and recording patients, visitors or staff without their consent. I understand Sparta Hospital will take appropriate action against these behaviors.

I understand that for my health and protection, as well as the protection of others, I am not permitted to bring or have any weapons, illegal substances or drugs, hazardous materials, alcoholic beverages, smoking materials, unauthorized electrical appliances, or other prohibited items on Sparta Hospital's premises. I understand that Sparta Hospital may search my belongings, as well as confiscate and dispose of any of these prohibited items, including providing them to law enforcement.

I agree that Sparta Hospital, and third parties acting for Sparta Hospital, may contact me by email or telephone (including phone calls, prerecorded messages using automated technology, or text messages) at any email address or number that I provide to Sparta Hospital, including wireless telephone numbers, for the purposes of communicating with me about my health care, requesting information about patient satisfaction, servicing my account, and/or collecting amounts due. I consent to receive emails, text messages, phone calls, and prerecorded messages using automated technology from Sparta Hospital, and/or any of their respective agents, representatives or business associates, including their billing service providers or debt collectors. I understand that consent to receive emails, text messages, phone calls, and prerecorded messages using automated technology is not required to receive health care services. I understand that emails and text messages may be sent unencrypted, which may present certain risks, including the risk of being intercepted during transmission or viewed by someone other than me. I agree to accept these risks. I am aware that I can ask to stop receiving texts and automated messages at any time. I can cancel these in any reasonable way. I am aware that Sparta Hospital does not charge me for these contacts, but my phone plan's standard message and data rates may apply. These costs are my responsibility.

**MY HEALTH INFORMATION:**

I consent to Sparta Hospital using or disclosing (sharing) my health information for treatment, payment or health care operations, and as described in Sparta Hospital's Notice of Privacy Practices. I give my permission to Sparta Hospital to release my health information to: (a) any of my other health care providers for continuing care, and (b) my insurance company and any federal, state or other agency responsible for paying for all or a part of my care, including the agencies that they use to review my care in order to receive payment, reimbursement, or plan for my treatment, procedures or discharge. I understand that discharge planning may include releasing my health information to another hospital, extended care facility or home health agency that may be involved in my care after discharge.

This includes the release of information related to behavioral and/or mental health, drug and alcohol abuse treatment records protected by 42 C.F.R. Part 2, HIV/AIDS and other communicable diseases, and genetic testing. I understand that my permission to release this information can be revoked (taken back) at any time, except for those records that have already been released. I understand this consent will be effective so long as reasonably necessary to provide care to me.



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I understand that Sparta Hospital cannot control how others that receive my health information will protect or use my information. I understand that others may not be required by law to protect my health information.

I understand that my medical records will be exchanged among my health care providers through a Health Information Exchange ("HIE"). My health information, including sensitive information, may be accessed by other providers, as permitted by law, for treatment, payment, and health care operations purposes. I understand that I have the option to opt out from sharing my health information with the HIE. I understand if I choose to opt out that my choice will not affect my ability to receive medical care.

**FINANCIAL CONSENTS AND ACKNOWLEDGMENTS:**

I agree to pay my bills and agree to have all insurance plans, benefit plans and health care service plans make payment directly to Sparta Hospital and physician(s). In consideration of all Sparta Hospital services, I assign to Sparta Hospital and the treating physicians, all of my rights and interest in any insurance proceeds, benefits (including Medicare, TRICARE/CHAMPUS, and Medicaid benefits), policy provisions, and/or judgments, payable to me or on my behalf. I direct any and all payors (including, but not limited to, all insurance companies, self-insurance benefit plans, whether governed by ERISA or not, personal injury protection benefits, uninsured and under-insured benefits, and health care service plans) to make payment on my behalf directly to Sparta Hospital and the treating physicians, as applicable.

I agree I am financially responsible for and agree to pay Sparta Hospital for all services, facilities and supplies provided to me at the established rates, including any deductible, co-payment or charges not covered by third party payors. Should the account be referred to a collection agency or to an attorney for collection, I accept responsibility for any costs, including attorneys' fees, incurred in the collection of these charges. I understand the Sparta Hospital bill may not include independent physician/practitioner services, and I may receive separate bills from those medical providers for their services. I am aware that some physicians who provide services to me at Sparta Hospital may not participate in the health plan or payment program that pays for my care, and I may have a greater financial responsibility for the payment of those services. I understand any questions I have regarding my insurance coverage or benefit levels should be directed to my health care plan and/or certificate of coverage. I certify that the information given by me for purposes of payment for treatment is complete and accurate.

If I do not have health insurance or have difficulty paying my bill, I understand that Sparta Hospital may be able to provide financial assistance options, including interest-free payment plans, discounted care, or free care, if I am qualified. Information about Sparta Hospital's financial assistance program, qualification criteria and whether or not my provider offers financial assistance is available from Patient Financial Services.

Sparta Hospital may charge a separate facility fee for certain services provided in a hospital clinic or in an emergency room setting. This fee is billed separately and in addition to the physician or provider fee. This split-billing in healthcare refers to the practice of issuing separate bills for different components of a single medical encounter, typically when care is provided in a hospital-owned outpatient facility or clinic. Facility fees are charged for the use of infrastructure and resources which generally cover operating expenses such as utilities, maintenance, housekeeping, nursing staff and administrative support, and other overhead costs incurred to operate and maintain facilities. The reason facility fees are charged separately is to ensure proper tracking of costs and revenues when Sparta Hospital contracts with independent providers for services. It allows insurers to reimburse healthcare provider claims differently when space, staff and expertise are managed and reimbursed separately. For additional information, contact our Business Office Manager at (618) 443-6821.



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By signing below, I confirm that I have read, understand and agree to the contents of this form, including the Notice of Non-Employed Independent Physician and Practitioner Services. I have been given the opportunity to ask questions, and I have no remaining questions at this time. I also acknowledge my signature on an electronic platform may appear different from my actual signature but confirm my signature is valid, binding, and enforceable.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature/Name of Interpreter (if applicable)

*Sparta Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Sparta Hospital does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.*