COPPER QUEEN COMMUNITY HOSPITAL (CQCH)

CQCH SATELLITE CLINICS:
COPPER QUEEN MEDICAL ASSOCIATES BISBEE
COPPER QUEEN MEDICAL ASSOCIATES DOUGLAS
PALOMINAS/HEREFORD RURAL HEALTH CLINIC

CONDITIONS OF ADMISSION & TREATMENT AGREEMENT & ASSIGNMENT OF BENEFITS ("COT/COA") FOR TREATMENT PROVIDED IN CQCH AND CQCH SATALLETE CLINICS

Patient: **Date:**

The undersigned _____, consents and agrees to the following terms of admission and treatment provided at CQCH and/or all of CQCH Satellite Clinics.

1. **MEDICAL AND SURGICAL CONSENT:** My healthcare providers will provide the direction for my health care and treatment. I consent to receive all medical, surgical and anesthesia treatment and hospital services as ordered by my health care providers, including physician and provider services, nursing services, diagnostic (i.e., lab, radiology, x-ray, etc.), therapeutic (i.e., medication, respiratory, physical therapy, occupational therapy, other therapy, etc.), technical and all other hospital services (i.e., emergency, pharmacy, nutrition, room and board etc.) provided under the instruction of my health care providers. My care will be under the control of my attending physicians.
2. **HOSPITAL RELATIONSHIP WITH DOCTORS:** <u>You may be billed separately by the physician who are independent contractors.</u> I understand and agree that some physicians furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, consultants and some other physicians, may be independent contractors and are not employees or agents of the Hospital, and the Hospital is not liable for the actions or inactions of the physicians. Physicians act independently and are not controlled or directed by CQCH in treating, consulting or otherwise furnishing services.
3. **RELEASE OF PATIENT INFORMATION:** I acknowledge the Hospital is authorized to disclose all or parts of my record, including without limitation, information pertaining to substance abuse, psychiatric, HIV and other information, in accordance with federal, state, and other applicable laws, including HIPAA. Some of my health information will be sent to Arizona Health Information Exchange, unless I opt out in writing.
4. **CONSENT TO RECORD, PHOTOGRAPH, AND FILM OR OBSERVE:** I consent to observation and/or demonstration during administration of medical treatment, surgical diagnostic procedures for the purpose of education of physicians, medical students, and student nurses and other proper student or technician whose presence is deemed appropriate by the attending physician. I consent to the recording, photographing, closed circuit monitoring or filming of me for purposes of treatment of the hospital's internal operations such as improvement of quality of care.
5. **EDUCATIONAL PROGRAMS:** Various educational programs conduct Student practicum at Copper Queen Community Hospital. The students are training under the supervision of a qualified instructor. If you prefer not to receive care by students, you have the privilege to refuse by notifying the Supervisory Nurse or your physician.
6. **PATIENT-OWNED ELECTRICAL APPLIANCES AND ELECTRONIC DEVICES:** Patient-owned electrical appliances are not permitted. Patient use of personal electronic devices (e.g. cell phone, laptop, computers, IPAD) may not be used for an illegal purpose. I will not film or record my treatment, hospital personnel, healthcare providers or other patients or visitors. I will not connect a computer or other device to the Hospital network without written permission.
7. **TOBACCO AND ALCOHOL FREE ENVIRONMENT:** I acknowledge that the Hospital and all of its locations are non-smoking and tobacco, alcohol and drug (non-medication) free. I agree that I will not use tobacco, other smoking products, alcohol and/or drugs while on Hospital property.
8. **PERSONAL VALUABLES/PERSONAL PROPERTY:** Hospital maintains a safe for the safekeeping of money and valuables. (Items secured in the safe may be retrieved ONLY between 8:00 and 5:00PM Monday through Friday). The Hospital shall not be liable for loss of or damage to any money, jewelry, electronic devices, documents or any other articles unless placed in the safe. For items deposited in the Hospital's safe, the limit of the Hospital's liability in case of loss or damage shall be $500.00. In addition, the Hospital shall not be

liable for loss of or damage to any personal property, such as bridge work, dentures, eyeglasses or clothing, retained in the possession of the patient during his/her stay in the Hospital.

9. **ADDITIONAL INFORMATION:** I acknowledge that I have received additional and pertinent information, such as the Notice of Privacy Practices, unless I have declined receipt.
10. **ASSIGNMENT OF INSURANCE AND SIMILAR BENEFITS TO HOSPITAL AND/OR CLINIC (COLLECTIVELY REFERRED TO AS "HOSPITAL"): If** I am entitled to hospital or medical benefits of any type, arising out of any policy of insurance insuring patient or any other party liable to patient, such benefits are hereby irrevocably assigned to the Hospital for application to patient's bill. The patient is responsible for charges not covered by this assignment. Patients eligible for Medicare and/or AHCCCS hereby authorize the Hospital to bill and collect from Medicare and/or AHCCCS directly. Any charges not covered by Medicare, AHCCCS or any supplemental insurance are the responsibility of the patient. As allowable by law, Hospital may disclose all or any part of the patient's record pertaining to this hospitalization, including information relating to HIV testing and treatment, psychiatric, alcohol and drug treatment records, to any person or corporation which is or may be liable under contract to the Hospital or to the patient or to a family member or employer of the patient for all or part of the Hospital's charge, including, but not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer. Pursuant to Arizona and Federal statute, I authorize the release of all my medical records, including HIV, psychiatric, drug or alcohol treatment records, for the purpose of securing contractual payments for services rendered during this hospital admission. I agree to cooperate with efforts to obtain payment from insurance and/or payors. I understand that if I fail to cooperate, my insurance plan/payor may deny coverage and I will be fully and solely responsible for payment. I further agree to pay all charges not paid by my insurance/payor, unless expressly prohibited by law or contract. I understand that the Hospital may charge me a late fee of up to 1.5% per month on all charges not paid within thirty (30) days of the date billed. I agree to pay any attorney fees and collection expenses if my account is sent to an attorney or collection agency for collection. I understand and agree that Hospital may assert a lien against any recovery I receive from liable third parties or their insurers. I agree to pay all usual and customary charges. I agree to make an advance payment, co-payment or deposit before services are rendered, if requested, and as allowable by law.
11. **ASSIGNMENT OF INSURANCE AND SIMILAR BENEFITS TO PHYSICIAN(S):** In the event the patient is entitled to benefits payable for physician services arising out of any policy of insurance insuring patient or any other party liable to patient, such benefits are hereby irrevocably assigned to the physicians providing those services. The undersigned further understands that all physicians do not accept assignment and that independent arrangements may need to be made for payment for physician services related to this admission.
12. **NO REVISIONS:** I acknowledge that the Hospital does not allow changes/revisions/modifications ("Revisions") to this document and that any such Revisions will not be honored or accepted by the Hospital

PATIENTS AGENT OR LEGALLY AUTHORIZED REPRESENTATIVE PATIENT

RELATIONSHIP TO PATIENT WITNESS

DATE TIME