GUNDERSEN
PALMER LUTHERAN
HOSPITAL AND CLINICS

Conditions of Admission or Authorization for Outpatient Procedures

Patient Information:

_____	_____	_____
Name - Last, First	Medical Record Number	Date of Service

Consent to Medical Care: I am presenting myself for admission or for outpatient procedure(s) to Gundersen Palmer Lutheran Hospital and Clinics. I consent to the rendering of medical care which is determined to be necessary or beneficial in the professional judgment of my medical provider. This includes routine diagnostic procedures and medical treatments by authorized agents and employees of the hospital, and by its medical staff or their designees. I understand that no guarantees have been made to me as to the results, the diagnosis, examination, and/or treatment of my condition. The treatment(s) and procedure(s) will be performed by physicians, members of house staff and employees of the hospital on the Date of Service listed above, or as part of an episode of care including the Date of Service.

Notice of On-Site Physician Coverage: Gundersen Palmer Lutheran Hospital and Clinics does not have a physician in the facility 24 hours per day. To meet your needs, if an emergency medical condition develops, a physician is on-call and readily available to come to the hospital.

Personal Valuables: I have been advised that patients are discouraged from bringing valuables to the hospital. I understand that the hospital is not responsible for loss of or damage to personal belongings which I choose to keep in my possession while I am a patient in this hospital. This includes dentures or eyeglasses which must be available for my daily use.

Release of Medical Information: I authorize disclosure of information from my medical record for the purpose of payment of my hospital charges. I agree to the transfer of medical information to the health care facility or service that will provide continuation of my health care. I understand that if I receive treatment for mental illness, HIV, developmental disabilities, drug or alcohol abuse, these records are included. I understand that content of my electronic medical record will be shared with Gundersen Health System and its affiliates.

Financial Agreement: I understand that my insurance coverage may not pay the total cost of the products or services provided to me by Gundersen Palmer Lutheran Hospital and Clinics. I acknowledge my obligation to pay the balance between what my insurance coverage will pay, if any, and what Gundersen Palmer Lutheran Hospital and Clinics can charge for these services and products. I further acknowledge that I will be responsible, and pay within 60 days from the date that the claim was submitted to my insurance payor, for the full amount of charges associated with any products or services I receive from Gundersen Palmer Lutheran Hospital and Clinics should my insurance payor deny payment for any reason (including, but not limited to, my failure to qualify for the products or services, non-coverage by my insurance payor, or my failure to provide complete and accurate information to Gundersen Palmer Lutheran Hospital and Clinics necessary for billing my insurance payor). I agree to remit to Gundersen Palmer Lutheran Hospital and Clinics any payments made directly to me by my insurance payor for products or services provided by Gundersen Palmer Lutheran Hospital and Clinics on an assigned basis. I agree to be responsible for my co-payment, annual deductible amounts, or the full amount in the absence of health insurance.

Physician Fees: I understand that I may receive separate bills from individual physicians for any services performed.

Assignment of Benefits: I certify that the information given by me in applying for benefits is correct. I assign payment of authorized benefits directly to Gundersen Palmer Lutheran Hospital and Clinics, West Union, Iowa. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries, any information needed for this or any related Medicare claim. I assign payment of benefits on my behalf to Gundersen Palmer Lutheran Hospital and Clinics.

Contact per cell phone: By providing Gundersen Palmer Lutheran Hospital and Clinics with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cellphone number for billing and debt collection purposes

- Gundersen Palmer Lutheran Hospital and Clinics will strive to honor my wishes to best of their ability.
- This consent can be revoked by me at any time.
- I accept non-safety closure lids on any medications dispensed through the emergency room or urgent care clinic for self administration.

- Pre-certification is not always a guarantee of payment. Gundersen Palmer Lutheran Hospital and Clinics is unable to determine prior to services how much a particular insurance company will cover, if at all.
- PLHC Patient Brochure given which includes: Message from Medicare Benefit Notice, Patient's Rights and
- Responsibilities, Information on Advance Directives, Sources for Home Nursing Agencies, and Home Medical
- Equipment/Supplies for inpatients.
- Information on Advance Directives given upon registration to Observation, SDS and ED patients.
- Visual monitoring may be used for patient safety.

I acknowledge that I have been informed of the 'Visitation Rights Notice.'

The undersigned certifies that he/she as the patient or other responsible party, has read the foregoing and understands And accepts the terms and conditions of this document.

_____ _____

Patient or Nearest Relative Relationship, if Applicable

_____

Reason Unable to Sign, if Applicable
Reason patient is unable to sign if applicable:
A. Verbal Permission
B. Incompetent due to physical/mental incapacity
C. Minor

_____ _____

Witness Witness #2

In the event of an Emergent condition and patient or nearest relative is unable to give consent upon admission, the patient's support person may acknowledge they have been of informed of their visitation rights and received the Visitors Rights Notice by signing the following:
I, the patient or designated support person, hereby acknowledge I have been informed of the 'Visitation Right Notice'. Furthermore, I understand that these rights may contain restrictions or limitations that might include but are not limited to those stated in the notice.

_____ _____

Support Person Relationship, if Applicable

_____ _____

Witness Witness #2