CONSENT AND CONDITIONS OF TREATMENT

Thank you for choosing Northwest Specialty Hospital to provide for your healthcare needs. We are committed to providing exceptional healthcare. The first step in this process is to provide information regarding patient rights, risks and responsibilities. The second step is to obtain your consent to treat the patient. The admitting staff can answer any questions you may have in regards to the following agreement.

I agree to the following:

1. **CONSENT TO TREAT:** I consent to the treatment or admission of ____________________ at Northwest Specialty Hospital for services or supplies that have been or may be ordered by a licensed professional healthcare provider. I understand that treatment may include but is not limited to: radiological examinations, laboratory procedures, physical therapy, anesthesia, nursing care or medical and surgical treatment. Your case may be attended by vendors and clinical students. I understand that all licensed professional healthcare providers that render service to the patient are responsible and liable for their own acts, orders and omissions. I acknowledge that the hospital has not made nor can it make a guarantee of the outcome of treatment.

2. FINANCIAL AGREEMENT: I agree to pay for all services and supplies rendered to the patient in accordance with the rates and financial policies in effect at the time of service. I authorize any overpayment made on this account to be transferred to any other account balance for which I am responsible. I agree to pay interest fees on any unpaid balance after 60 days of discharge or date of service at a rate not to exceed 18% APR. If this account is assigned to an attorney or a collection agency for collection then I agree to pay all collection agency fees, court costs, and attorney's fees.
   - ❏ I am aware that financial counseling is available for any services that I may receive during my visit at Northwest Specialty Hospital.

3. ASSIGNMENT OF INSURANCE BENEFITS: I assign and authorize payment directly to Northwest Specialty Hospital of any healthcare benefits that the patient is entitled to receive. This assignment will not be withdrawn or voided at any time unless I pay the account in full. I understand that I am responsible for any and all charges not covered by my insurance policy(s). If the patient is entitled to Medicare or Medicaid benefits under Title XVIII of the Social Security Act, I request assignment of benefits directly to Northwest Specialty Hospital.

4. ASSIGNMENT OF PHYSICIAN BENEFITS: I am aware that physician services by Radiologist, Pathologist, Anesthesiologist, as well as medical, surgical and emergency care are not billed by the hospital but are billed separately. I understand that I am under the same obligation to those providers as stated in this agreement unless otherwise agreed to in writing with those providers. I authorize payment of any medical benefits for such claims to the appropriate provider.

5. RELEASE OF MEDICAL INFORMATION: I authorize the hospital or any professional healthcare provider who rendered services to the patient to release any medical or other information necessary to process claims.
   - ❏ I acknowledge that I have received a copy of the Privacy Notice.
   - ❏ I decline to accept a copy of the Privacy Notice.

6. PERSONAL VALUABLES AND BELONGINGS: I understand that the hospital maintains a safe for the protection of valuables. I agree that the hospital is not responsible for the loss or damage of any article or personal property unless they are deposited in the safe and a receipt issued.

7. **ADVANCE DIRECTIVE/LIVING WILL:** Northwest Specialty Hospital honors the patient's right to formulate, review or revise their Advance Directives or Living Will and can refer you to resources for assistance if necessary.
   - ❏ I have provided a copy of my Advance Directive or Living Will and request that it be put in my chart as part of my Medical Record.
   - ❏ I have received information with regard to my right to make Advance Healthcare Directives.
   - ❏ My Advance Directive or Living Will is suspended for this elective procedure.
   - ❏ I have not provided nor do I have an Advance Directive or Living Will and I decline information on Advance Directives.
   - ❏ I understand if my Advance Directive or Living Will **is not present** in my medical record its directives **will not** be followed.

   Action taken by admission clerk: ____________________

8. **RIGHT TO DONATE ORGANS:** The patient understands that they have a right to donate organs and they have discussed their decision with their family. Should circumstances arise please do the following:
   - ❏ Speak with the family regarding the matter.
   - ❏ The patient does NOT wish to donate. Please DO NOT speak to the family in regards to the matter.
   - ❏ I wish to donate my organs.

I understand and accept the terms of this agreement and certify that I am duly authorized by the patient or by law to execute the above agreement in their behalf.

Patient ____________________ Date ______/______/______ Time ____________

____________________ ____________________ ____________________

Patient's Guardian or Representative Relationship Witness

NORTHWEST SPECIALTY HOSPITAL
PATIENT RIGHTS AND RESPONSIBILITIES

As a patient, you have the right to the following:

- Considerate, respectful, uniform care that fosters the patient's dignity, autonomy, positive self-regard, civil rights, and involvement in care. To auditory, visual and personal privacy to the extent possible with recognition of your personal dignity; access to telephone privacy, at your request.
- Remain free from restraints unless medically or behaviorally necessary to ensure safety for you and others; be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.
- Receive care in a safe setting free from neglect, exploitation, verbal, mental, physical, and sexual abuse and/or harassment and to be provided protective services as requested or required.
- Expect equal medical treatment regardless of race, color, ethnicity, age, religion, culture, language, physical or mental disability, sexual orientation, marital status, gender identity or expression or socioeconomic status.
- Expect that your statements about pain will be believed and that your pain will be managed appropriately and receive reassessment as appropriate for management of identified pain.
- To be well-informed about your illness, effective communication, possible treatments, likely outcome and to discuss this information with your physician. A patient has the right to participate in the development and implementation of his/her plan of care and involve family or support persons of your choice.
- The right to be assured your physician and your family (a family member or other representative of choice) will be promptly notified when you are admitted to the hospital.
- To an interpreter by verbal, written or signed communication when you do not speak the predominant language of the community.
- To consent to or refuse a treatment, as permitted by law. If you refuse a recommended treatment, you will receive other needed and available care. The hospital will honor the right to formulate, review and revise advanced directives.
- Informed consent, to participate in care decisions. Know about hospital rules that affect you and your treatments; information about charges and payment method.
- Appoint a surrogate decision maker to speak in your behalf if you lose the ability to communicate your wishes regarding possible treatment alternatives and to expect that your advance directive will be followed.
- Consent to or decline to take part in research affecting your care. If you choose not to participate, you will receive the most effective care the hospital otherwise provides. Be informed of care alternatives if hospital care is not appropriate.
- Examine and receive explanations of your bill regardless of the source of payment. Effectiveness , safety, treatment and services does not depend upon ability to pay. Know hospital rules that affect you and your treatments.
- Ask and be informed of the existence of business relationships among the hospital, educational institutions, and other health care providers or payers which may influence your care or treatment.
- Expect your medical record will be held in the highest confidentiality and that only individuals involved in your care or monitoring quality will have access. To allow access to, request amendment to, and to obtain information on disclosures of his or her health information, in accordance with law and regulation.
- Know the identity and professional status of individuals providing care and services ; physician or other practitioners primarily responsible for your care.
- Grant visitation access to all individuals designated by the patient or support person for emotional support during the course of stay.
- Voice complaints, have them reviewed by the hospital, recommend changes freely without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care. To be informed of unanticipated outcomes of care, treatment, and services that relate to sentinel events considered viewable by The Joint Commission.
- The right to file your complaint with the hospital or with an external agency. The complaint or grievance can be submitted via phone or mail:

  Chief Nursing Office, 1593 E. Polston Ave. Post Falls, ID, 84854 (208) 262-2313

  Idaho Department of H and W; Bureau of Facility Standards,
  3232 Elder Street PO Box 83720, Boise, ID 83705-0036 (208) 334-6626, fsb@dhw.idaho.gov

  The Joint Commission, Office of Quality Monitoring,
  One Renaissance Boulevard, Oakbrook Terrace, IL 60181 (630) 792-5636, complaint@jointcommission.org

Patient Responsibilities:

- Has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health.
- Is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders. The patient is responsible for making it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
- Is responsible for keeping appointments and for notifying Northwest Specialty Hospital or physician when he/she is unable to do so. The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
- Is responsible for assuring that the financial obligations of his/her hospital care are fulfilled as promptly as possible. The patient is responsible for following hospital policies and procedures. The patient is responsible for being considerate and respectful of the rights of other patients and hospital personnel and of his/her personal property and that of other persons in Northwest Specialty Hospital.