UCSF Medical Center

UCSF Benioff Children's Hospital

UNIT NUMBER

PT. NAME

BIRTHDATE:

DATE OF SERVICE:

TERMS AND CONDITIONS OF SERVICE: ADMISSION, MEDICAL SERVICES, AND FINANCIAL AGREEMENT (Page 1 of 3)

1. **UCSF MEDICAL CENTER:** is part of the University of California and is comprised of its hospital(s) (UCSF Medical Center, UCSF Medical Center at Mt. Zion, and UCSF Benioff Children's Hospital), its hospital-based clinics, its Primary Care Network clinics, and the UCSF School of Medicine.

2. **MEDICAL CONSENT:** I consent to medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, taking of treatment related photographs, videotaping, laboratory procedures, and hospital services rendered to me under the general and special instructions of the physicians or other health care professionals assisting in my care. To facilitate my care, I consent to evaluation and examination by a physician or other health team professionals who may be physically distant from me via telehealth technologies, including but not limited to two-way video, digital images, and other telehealth technologies as determined by my providers. I also consent to my admission to the UCSF Medical Center if this is necessary for my care.

   I understand that I may be receiving education and instructions about my medical condition. UCSF Medical Center uses a variety of methods and vendors for this education and instruction and I consent to receiving this instruction using those methods and vendors, including, but not limited to Oneview, EMMI, Healthwise and Healthnuts.

3. **TEACHING, RESEARCH AND HEALTHCARE INSTITUTION:** The University of California including UCSF Medical Center, is a teaching, research and healthcare institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, x-ray, rehabilitation therapy), post-graduate fellows, and other trainees and visiting professors may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of the University's medical education programs.

   I also understand that a University institutional review board approves projects conducted by the University researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

4. **USE OF MEDICAL INFORMATION AND SPECIMENS:** I understand that my medical information, photographs, and/or video in any form may be used for other UCSF Medical Center purposes, such as quality improvement, patient safety and education. I also understand that my medical information and tissue, fluids, cells and other specimens (collectively, "Specimens") that UCSF Medical Center may collect during the course of my treatment and care may be used and shared with researchers and any such use will be in accordance with state and federal law, including all laws and regulations governing patient confidentiality, in the manner outlined in the UCSF Medical Center Notice of Privacy Practice. I understand that under California law, I do not have any rights to any commercially useful products that may be developed from such research.

5. **PERSONAL VALUABLES:** UCSF Medical Center asks patients and families not to bring valuable items into its facilities. UCSF Medical Center shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, cell phones, electronic devices or other articles of unusual value and shall not be liable for loss or damage to any personal property, unless deposited in the fireproof safe maintained by UCSF. The liability for loss of any personal property deposited with UCSF Medical Center shall be no more than $500.

6. **RELEASE OF MEDICAL INFORMATION:** The State of California Information Practices Act requires UCSF Medical Center to provide the following information to individuals who supply information about themselves. As a patient of UCSF Medical Center, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history and treatment. The princi-

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pal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. Under federal and state laws and regulations, UCSF Medical Center is authorized to maintain this information. As required by UCSF Medical Center, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage.

UCSF Medical Center will obtain my written authorization to release information about my medical treatment, except in those circumstances when UCSF Medical Center is permitted or required by law to release information (see UCSF Medical Center's Notice of Privacy Practices for a description of the specific circumstances under which UCSF Medical Center may release this information). For example, UCSF Medical Center may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with cancer, a reportable disease in California, UCSF Medical Center is required by law to report my diagnosis to the State Department of Health Services.

7. **SMOKING:** Smoking is NOT allowed on the campuses of UCSF Benioff Children's Hospital, UCSF Medical Center and UCSF Medical Center at Mount Zion (herein referred to as the Medical Center). Smoking has been determined to be hazardous to your health. If you are a smoker, we advise you to stop smoking. If you have a recent history of smoking in the last year, we advise you to continue to stop smoking. Alternatives to help curb your cravings for nicotine are available. Patients are not allowed to leave the hospital to smoke. Please speak with your clinical team to learn more about these alternatives or if you have any questions concerning smoking cessation. This policy applies to patients and visitors of the Medical Center.

8. **BEHAVIOR:** UCSF has a zero tolerance for intimidation, violence, and discrimination in our facilities. As such, UCSF is committed to maintaining a safe workplace that is free from threats and acts of intimidation, violence, and discrimination. For the safety and security of our patients, visitors and staff, weapons, knives, alcohol, illegal drugs and other dangerous materials are not allowed in our facilities. It is the expectation of the Medical Center that you and your visitors conduct yourselves in a respectful, non-violent, non-discriminatory, and non-abusive manner and that you do not leave the hospital at any time during your stay. It is against hospital policy for you to leave your assigned unit with property belonging to the hospital (example: gowns, IV machines, oxygen tanks, etc.). You may be discharged if you leave the hospital without informing your clinical team or if you repeatedly violate the hospital's smoking policy.

   I also understand that under California law I or my visitors cannot film, record, or disclose any images or sounds of our/my conversation with a UCSF employee or physician without the consent of all parties to the conversation and that violation of this law may result in criminal or civil liability. Please refer to your patient handbook for more information concerning your stay here at UCSF's hospitals and facilities.

9. **FINANCIAL AGREEMENT:** I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the service I receive, I agree to pay The Regents of the University of California for professional, hospital and clinic services, including UCSF Medical Center physician services, in accordance with the regular rates and terms of UCSF Medical Center. I also agree to pay for other professional services provided at UCSF Medical Center by other health care providers. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial

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guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.

10. **ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS):** I authorize and direct payment to UCSF Medical Center of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to or on my behalf for UCSF Medical Center services, including emergency services, at a rate not to exceed UCSF Medical Center actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to UCSF Medical Center by me. Patients insured by Part A of the Medicare Act (as primary payer): UCSF Medical Center shall transfer title prior to use of any property (excluding fixed assets or equipment) furnished or supplied to its patient or other customer in connection with its medical services billed pursuant to Medicare Part A. Notwithstanding this title provision, patient accepts that the disposal of medical products or other supplies after use will be governed by UCSF Medical Center handling and disposal protocols.

I have read, agreed to and received a copy of this Terms and Conditions of Service.

_____

Signature of Patient or Signature of Patient Representative

_____

Signature of Witness (required if patient unable to sign) Relationship of Representative to Patient

_____

Signature of Interpreter Language Used

Date of Signing _____

Elective Section:

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 9) and Assignment of Benefits (including Medicare Benefits) (Paragraph 10) set forth above.

_____ _____ _____

Date Financially Responsible Party Witness

PATIENT RIGHTS NOTICE: (This question only applies to inpatient admissions only)
Would you like your agent under a durable power of attorney for health care or your next of kin to receive a copy of the Patient Rights and Responsibilities Notice? If so, please ask your admitting representative or contact the Patient Relations Department at (415) 353-1936.

500-0512C (Rev. 05/17) MEDICAL RECORD COPY GENERAL WITH FINANCIAL AGREEMENT