Welcome !!

Thank you for choosing Phoenix Cyberknife and Radiation Oncology.

In an effort to make your initial visit both pleasant and efficient, we have several patient information forms to be completed before your appointment. This information will be used to prepare your medical chart.

Please complete these forms and bring them with you 30 minutes prior to your appointment, or you may fax or mail the completed forms to our office prior to your appointment. When you arrive, we will photocopy your insurance card and driver's license. If you have a copy of your medical records and or radiology scans on CD, you are welcome to mail, fax or bring them by our office, as our providers like to review your history 1 to 2 days prior to your appointment. Also note that some of the paperwork will be for Honor Health, these forms are for billing purposes for your treatment.

If your insurance company requires a referral or authorization number for you to see a specialist, please contact your primary care physician for the necessary referral or authorization number. Any co-payments for the initial consultation are payable at the time of service. We accept cash, check or credit cards.

A nurse will be seeing you prior to your visit with the physician. At that time she will go over your medications and medical history, so please bring your medications and a list of any physicians currently involved in your care.

If you have any questions or need assistance, please feel free to call our office between 7:30am and 4:30pm, Monday through Friday.

On behalf of Phoenix Cyberknife and Radiation Oncology, we look forward to meeting you and helping you with your medical needs.

Sincerely,

Your Phoenix Cyberknife and Radiation Oncology Team

Phone 602-441-3845
Fax 602-464-9769

AUTHORIZATION TO RELEASE PROTECTED MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

By signing below I give permission for the institution listed to disclose my protected health information to Phoenix Cyberknife and Radiation Oncology Center:
Person/Institution: _____
Address: _____
Phone: _____ Fax: _____

This protected health information is being used or disclosed for the following purpose:
Medical consultation, follow-up appointment, and/or treatment

Information to be disclosed **Dates (if known):** _____

- ☐ Most Recent History and physical
- ☐ Discharge summary
- ☐ Initial consultation note
- ☐ Most Recent progress note
- ☐ All radiology reports and imaging discs or dates specified: _____
- ☐ All Operative reports or dates specified: _____
- ☐ All Pathology reports or dates Specified: _____
- ☐ Most recent laboratory results
- ☐ Chemotherapy records
- ☐ Radiation therapy records: Initial Consult, treatment summaries, treatment plans, plan images.
- ☐ Other_____

Date by which the information is needed: _____

Send Records to:
4611 E SHEA BLVD, SUITE 120
PHOENIX, AZ 85028
P: 602-441-3845
F: 602-464-9769

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

You may revoke this authorization in writing at any time by sending written notification to Phoenix Cyberknife and Radiation Oncology Center, 4611 E. Shea Blvd, Ste 120, Phoenix, AZ 85028. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

This agreement will expire one year from the date of signature unless cancelled by the patient/guardian.

_____ _____
Signature of Patient Date

_____ _____
Legal Guardian / Patient Representative / Relationship to patient Date

PATIENT PERSONAL INFORMATION

Name : _____ DOB: _____ Sex: _____

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Other _____ Preferred Language: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unwilling to Provide ☐ Unknown
Address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership
Social Security #: _____

Employer _____ Occupation _____
Street Address: _____
City: _____State: _____ Zip: _____

RESPONSIBLE PARTY INFORMATION ☐ Same as Above
Responsible Party _____ DOB _____/_____/____
Relationship to Patient ☐ Self ☐ Spouse ☐ Other _____ SSN _____-_____-_____
Street Address _____ Apt #_____
City _____ State _____ Zip _____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
Work Phone (_____) _____-_____
Employer _____ Occupation _____

PATIENT INSURANCE INFORMATION Please present insurance card at check-in
Name of Insured _____

Primary Insurance Company _____
Patient relationship to Insured ☐ Self ☐ Spouse ☐ Other _____
Insurance ID _____ Group # _____

Secondary Insurance Company _____
Patient relationship to Insured ☐ Self ☐ Spouse ☐ Other _____
Insurance ID _____ Group # _____

EMERGENCY CONTACT

Name _____ Relationship _____
Address_____
Street, City, State, Zip
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Are we able to discuss your medical information with your emergency contact: ☐Yes ☐No

I have received a copy of the Privacy Rules from this practice

Signature: _____Date: _____

How were you referred you to our office?

Please check one:

☐Previous patient of our office: _____ ☐Facebook/LinkedIn ☐Insurance Provider ☐Friend/Family ☐TV/Commercial ☐Phoenix Magazine ☐PCROC Website ☐ Google Search

☐Physician (Name): _____ ☐ Other _____

Demographics and Consent to Communicate Update Form

Patient Name:	DOB:	Home Phone:
Patient Address:		Cell Phone:
Insurance:		
Primary		
Secondary		

Please mark the Preferred Method of communication

Method of Communication	Phone Number	Preferred Method of Contact	OK to leave a Message	OK to leave a message with another person
☐ Home Phone		☐	☐ YES ☐ NO	☐ YES ☐ NO
☐ Cell Phone		☐	☐ YES ☐ NO	☐ YES ☐ NO
☐ Work Phone		☐	☐ YES ☐ NO	☐ YES ☐ NO

If it's OK to leave a message with another person, please list them:

NAME	Relationship	Phone Number	OK to Release Test Results
			☐ YES ☐ NO
			☐ YES ☐ NO

PCROC has implemented a **secure patient portal** for you to easily access your patient appointments, medication list and End of Treatment Summaries from a secure website. You can also easily email our office staff securely regarding appointments or other NON Emergent requests.

As our patient, you have been set up to access our patient portal. You will need to access the secure patient portal using your unique pin number. If you do not have that number, we can provide this to you.

You must provide an email address for portal access.

Email Address for portal:	

We are happy to send electronic preventative care reminders, please let us know your ***SINGLE* preferred method to receive these reminders.

☐	Text	Mobile #: Phone Carrier:
☐	Email	Email address:

I understand I am allowing personal and medical necessity communication in the above stated methods. I have the right to change my mind at any time by requesting a new communication consent form. It will be my responsibility to always ensure my phone numbers and email address (es) are correct and will notify my doctor's office of any changes.

Patient Signature: _____ **Date**: _____

PHYSICIAN LIST

Name : _____ DOB: _____

To help us ensure continuity of care, please provide us with the following list of all doctors involved in your care. If at any time, you add, change or drop a physician please let our office know so that we may continue to keep the proper doctors informed. Thank You.

Referring Physicians - Address including Specialty

Specialty: _____Name: _____

Phone#: _____Address:_____

_____

Specialty: _____Name: _____

Phone#: _____Address:_____

_____

Specialty: _____Name: _____

Phone#: _____Address:_____

_____

Name of Pharmacy: _____ Phone # (_____) _____
Location: Major Cross Road _____

REVIEW OF SYSTEMS WORKSHEET

Name : _____ DOB: _____ Age: _____

Brief Explanation for Today's Visit:

_____

_____

__

Past Medical History:

Have you had radiation treatment in the past? ☐Yes ☐No
If yes, to what part of body? _____
When: ___/___/___ Facility: _____
Have you had chemotherapy in the past? ☐Yes ☐No
When: ___/___/___ Facility: _____
Are you currently undergoing chemotherapy? ☐Yes ☐No
Date of last dose: ___/___/___ Facility: _____

Any previous surgeries: ☐Yes ☐No
Type: _____ Date: _____ Facility: _____

_____

_____

_____

___

Implanted Devices: Do you have any implanted or metal devices? ☐Yes ☐No
☐Venous Access Device/Type_____ ☐Pacemaker ☐Aneurysm Clip
☐Screws, pins, plates/Where? _____ ☐Stent ☐Other _____

Do you have? ☐ Diabetes ☐Thyroid Problems ☐Other:

_____

_____

_____

___

Smoking History:

Have you ever smoked? ☐Yes ☐No (If yes, please answer the following questions)
Do you currently smoke? ☐Yes ☐ No # of Packs per Day: _____ Number of years: _____
If you have quit smoking: When: _____/_____/_____

Alcohol Consumption:

Do you consume alcohol? ☐Yes ☐No
If yes: How often? _____ How much? _____

Controlled Substance Usage:

Do you currently use controlled substances? ☐Yes ☐No
If yes: What substance? _____ How often? _____ How much?
_____

Gynecological: (Females Only)

# of Children: _____ # of Pregnancies: _____ # of live births: _____ Other: _____

How old were you when your 1st child was born? _____
Did you breastfeed? ☐ Yes ☐ No How Long? _____
Age at 1st Menstrual Period: _____ Last Menstrual Period: ___/___/___
Last Pelvic Exam/PAP: ___/___/___
Hormones: ☐Yes ☐No Name: _____ How Long? _____
Hysterectomy: ☐Yes ☐No When: _____/_____/_____ Why? _____
Do you do self breast exams? ☐Yes ☐No How often? _____
Type of birth control currently used: _____
Date of last mammogram: _____/_____/_____ Facility: _____

Family History:
Is there any family history of cancer? ☐Yes ☐No (If yes; Who? And what type of cancer?)
_____
_____
_____
___

Allergies:
☐ None
☐Latex Reaction: _____
☐ Medications: Drug: _____ Reaction: _____
Drug: _____Reaction: _____
Drug: _____Reaction: _____

Weight: _____lbs Height: _____ft_____in

Please provide us with a list of current medications:

Medication	Dosage	Frequency	Purpose of Medication

If you need more space, please use reverse side

Review of Systems: (please check all that apply to your health)

General:
Please rate your level of fatigue 0-10 (0=none, 10=severe): _____
Are you now experiencing pain? ☐Yes ☐No If so, where? _____
Please rate your pain level 0-10 (0=none, 10=severe): _____

Do you experience any of the following?
☐ Fever ☐ Chills ☐ Night Sweats ☐ Sleep Problems
Please explain: _____

Skin:
☐ No problems
☐ Rashes ☐ Itching ☐ Skin Cancers ☐ Burn easily in sun ☐ Other_____

Heart:
☐ No Problems
☐ Blood Pressure Problems ☐ Bruising/Bleeding ☐ Palpitations
☐ Swollen Ankles ☐ Heart Attack/when? ___/___/___ ☐ Other_____

Neurological:
☐ No Problems
☐ Memory Loss/Forgetfulness □ Fainting Spells/Dizziness □ Visual Complaints □Claustrophobia
☐ Seizures/Convulsions □ Headaches/Migraine History □ Hearing Complaints □ Stroke
☐ Other _____

Respiratory:
☐ No Problems ☐ Received Flu Vaccine: Month/Year: _____
☐ Shortness of Breath: ☐ At Rest ☐ With Activity
☐ Home Oxygen (LPM_____) ☐ Hoarseness ☐ Breathing Medications ☐ Asthma ☐ Other: _____
Do you have a cough? ☐ Yes ☐ No If yes, does it produce: ☐ Blood or ☐ Phlegm?

Skeletal/Muscular:
☐ No Problems
☐ Arthritis ☐ Numbness/Tingling ☐ Weakness/Balance Problems ☐ Back/Neck Pain
☐ Blood Clots: Where? _____
☐ Collagen Vascular Disease (i.e. Lupus, Scleroderma, etc.)

Digestive:
Appetite: ☐ Good ☐ Fair ☐ Poor
Weight Loss: Have you lost weight in the last 6 months? ☐ Yes ☐ No If yes, How much?:_____
☐ No Problems
☐ Nausea/Vomiting ☐ Heartburn/Reflux ☐ Ulcers/Hiatal Hernia ☐ Swallowing Problems
☐ Sores in Mouth ☐ Chewing Problems ☐ Dentures
☐ Other_____
Do you follow a special diet? (If so, please explain) _____

Date of last Colonoscopy: _____

Urinary
☐ No Problems
☐ Burning ☐ Frequent ☐ Discomfort ☐ Catheter ☐ Ostomy ☐ Urinary Tract Infections
☐ Incontinence (unable to hold bladder) ☐ Other_____

Bowel
☐ No Problems

☐ Diarrhea ☐ Constipation ☐ Stool Incontinence (loss of control) ☐ Ostomy
☐ Liver Disease/Hepatitis ☐ Other_____
Last BM:_____ Frequency of BM: _____

If you have further information, which you feel would allow us to provide you with better care, or have special needs that must be addressed, please write it in the space below.

_____

_____

_____

_____

_____

_____

Assignment of Insurance Benefits
I hereby authorize payment to Radiation Oncologists of Central Arizona, Phoenix Cyberknife and radiation Oncology Center and to the physician(s) and specialist physician(s) involved in my treatment. The insurance benefits specified on my admission form and for other insurance carriers, otherwise payable to me but not to exceed the balance due for the regular charges for the period of treatments.

Insurance Assignment and Release
I, the undersigned certify that I have insurance coverage with and assign directly to Radiation Oncologists of Central Arizona, Phoenix Cyberknife and Radiation Oncology Center, and other physicians related to my course of treatment, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby expressly guarantee payment in full of any and all charges in consideration for medical services rendered I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this Signature on all insurance submissions.

Medicare Authorization
I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its Medicare contractors any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I understand I am responsible for any health insurance deductible and Coinsurance amounts where applicable.

Authorization of release of Information for Insurance Benefits
I hereby authorize and direct Radiation Oncologists of Central Arizona, Phoenix Cyberknife and Radiation Oncology Center, and the Physicians having treated me, to release to governmental agencies, Insurance Carriers or others who are financially liable for my hospitalization and medical care all information needed to substantiate payments for such hospitalization and medical care and to permit representatives thereof to examine and make copies of II records related to such treatment.

Authorization for Appeal
The Federal/State government and third party insurers often require that a patient's medical treatment be justified by a review organization. Where a claim for payment is denied by the reviewing organization, it becomes necessary for the clinical to ask for reconsideration and sometimes to make an appeal to a government agency or third party insurer on your behalf. To enable us to take these steps to obtain payment of your medical bill, we ask that you please sign the authorization below. I hereby authorize Radiation Oncologists of Central Arizona, Phoenix Cyberknife and Radiation Oncology Center, and other physicians related to my treatment to take all necessary steps on my behalf to seek reconsideration and, if necessary, an appeal to the appropriate agency having jurisdiction, of any adverse determination which affects the allowance of Medicare, Medicaid Blue Cross or other Commercial Insurance reimbursement relating to Radiation Oncologists of Central Arizona , Phoenix Cyberknife and Radiation Oncology Center, and other physicians related to my treatment.

Financial Agreement.
For and in consideration of services rendered or to be rendered by Radiation Oncologists of Central Arizona, Phoenix Cyberknife and Radiation Oncology Center, and other physicians related to my treatment to the patient whose name appears above, the," undersigned (jointly and severally if more than that one) hereby agree(s) to be fully and totally responsible to Radiation Oncologists of Central Arizona, Phoenix Cyberknife and Radiation Oncology Center, and other physicians related to my treatment for payment I all charges as submitted by the clinic on account of the patient and to make payment in accordance w h the policy for payment of bills at the clinic. It is further agreed that the charges incurred represents the fair and reasonable value of the services rendered and are in accordance with the posted charges of the clinic which are available upon request. Payment may be demanded at any time and the demand for payment of the patient shall be a prerequisite to my (our) immediate responsibility for payment.

Patient, responsible party(ies), or authorized agent Date

Witness Date

Name : _____ DOB: _____

Insurance and Billing Policy

Our policy is to bill the patient after insurance has had the opportunity to consider the charges. Patients who are self pay are responsible for the entire balance for all services rendered by the physicians of Radiation Oncologists of Central Arizona and Phoenix Cyberknife and Radiation Oncology Center.

Due to numerous changes in healthcare over the past several years, it has made it impossible for our office to keep aware of every plan and all of its rules and changes. We strongly encourage you to verify that our providers are covered under your specific plan/network. Your signature below confirms that you have verified your insurance benefits and if your services are not covered you may be held financially responsible.

Please advise our office if there are any changes in your insurance information you are accountable and could be responsible for the full balance. Should you have any questions concerning your account, or if you wish to speak to your account manager, please call 800-228-3565, extension 5813 between the hours of 8:30 am and 5:00 PM EST, Monday through Friday. If this phone number does not pertain to your account please call our office.

I authorize Radiation Oncologists of Central Arizona, Phoenix Cyberknife and Radiation Oncology Center, and other physician(s) related to my treatment to bill my insurance company for charges incurred during the course of my treatment, and to provide any medical information necessary to process this claim. I understand that there may be additional charges for the surgeon that participated in the treatment planning process and there will be a bill sent to me separately by them. I authorize payment to be made directly to Radiation Oncologists of Central Arizona, Phoenix Cyberknife and Radiation Oncology Center, and other physicians related to my course of therapy and a copy of this authorization may be used instead of the original. I authorize Radiation Oncologists of Central Arizona and Phoenix Cyberknife and Radiation Oncology Center and other physician(s) related to my treatment to inquire about my accounts and to receive any information about any and all of my Medicare, Blue Shield or other insurance claims, assigned or non-assigned and I understand that I am fully responsible for charges incurred with the treatment even though the doctor files my insurance for me. I understand that delinquent accounts are subject to collection and acknowledge responsibility.

I have read and understand the above insurance and billing policy.

_____ _____

Patient or responsible party(ies) Signature Date

_____ _____

Witness Date

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Phoenix Cyberknife and Radiation Oncology LLC is dedicated to protect your "nonpublic personal health information." This is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:

Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card and driver's license. This ensures you that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain the information from the hospital. However, on your first visit to this office we will ask you to fill out our information sheet to insure that the information we received from the hospital was correct.

We may also ask a doctor or other healthcare provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:

We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:

To insure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION?

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Government Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:

We release your records only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Health Information.

IF you leave this practice, your Protected Health Information will continue to receive the protection outlined in this notice.

COMPLAINTS/COMMENTS: If you have any complaints concerning our privacy practices, you may contact the privacy officer of this practice at 602-441-3845.

This Practice reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to our policy will be posted in our office. This notice is effective as of February 21, 2013.

LATE ARRIVALS NOTICE

To our patients and their families:

We value your time, as well as our own. Our practice functions on a very tight schedule, and we strive to be on time for *every* patient. Appointments are made to keep everyone on time, including physicians, for other commitments. We cannot tolerate late arrivals, even if you are only late by a few minutes.

If you arrive after your appointed time, we will make a sincere effort to work you into the schedule that day, if possible, but *we may need to reschedule you for another date or you may need to wait that day until a time is available.* This is mainly done in order to protect the time of other scheduled patients coming after you.

Unfortunately, late arrivals are occurring much more often recently. As always, we recommend that you arrive *well in advance of your appointment time* in order to avoid situations that require you to reschedule.

Please understand that this policy is in place to respect and protect everyone's time commitments.

Please sign below to verify you received this document

X_____

CONDITIONS OF ADMISSION AND TREATMENT

HonorHealth, a non-profit acute care facility, is dedicated to providing the very highest quality care and world class service to all its patients.

The Patient, or the person authorized to act for the Patient, ("I" or the "Patient") agrees to the following terms of admission:

CONSENT TO TREATMENT: I understand that Patient's physicians control the Patient's health care. I consent to Patient receiving all medical and surgical treatment as ordered by the responsible physicians, including physician services, nursing services, technical services, laboratory procedures and tests, anesthesia, radiologic and diagnostic examinations, emergency treatment, room and board services and other hospital services rendered under the general or special instructions of Patient's physicians. I agree that this consent to treatment shall be valid until Patient is finally discharged.

PHYSICIANS: I understand that most physicians that care for patients at the Hospital are not employees or agents of the Hospital, but are independent contractors. I understand that physicians are responsible for their own treatment activities and that the Hospital is not liable for the actions or omissions of physicians who are not employees of the Hospital. I understand that if I want to know whether physicians are employees of the Hospital, I should ask the physicians.

Emergency Services Notice: I understand that if the Patient comes to the Hospital requesting care and treatment for an emergency medical condition, the Hospital is obligated to provide me with a medical screening examination and any stabilizing treatment or transfer regardless of Patient's ability to pay for those services.

GENERAL DUTY NURSING: The Hospital Provides only general duty nursing care. The Hospital is not responsible for providing continuous or special duty nursing care, and nurses are called to patient's bedside by a signal system. If patient desires continuous nursing care if not necessary based on the Patient's medical needs, then Patient or Patient's physician must arrange for such care independent from the care provided by the Hospital. Patient will bear the financial responsibility for the cost of continuous or special duty nursing care that is not medically necessary. Patient releases the Hospital from liability arising from the lack of continuous monitoring or special duty nursing care beyond the care the Hospital determines is necessary based on Patient's needs.

HONORHEALTH™

CONDITIONS OF ADMISSION AND TREATMENT

MEDICAL AND SURGICAL CONSENT: The patient's care is under the control of his attending physician(s) and the hospital shall not be held liable for following instructions of the physician. The UNDERSIGNED CONSENTS to any radiological examinations, laboratory procedures, anesthesia, medical or surgical treatment or hospital services rendered the patient consistent with the instructions of the physician. Information that explains HIV infection and the meaning of a positive test is provided. If the physician orders an HIV test, the patient and/or their representative may ask their healthcare provider questions and are given the opportunity to decline testing at that time. The UNDERSIGNED recognizes that all physicians furnishing services to the patient, including, but not limited to the hospitalists, radiologists, pathologists, anesthesiologists, emergency physicians, wound care clinic physicians, those working in the hyperbaric lab or any other specialists who are independent contractors and not employees of the hospital. They will be billing for their services separate from the hospital and may or may not be contracted with your insurance carrier.

TEACHING PROGRAMS: The Hospital participates in programs for training of health care personnel. Some services may be provided to the patient by persons in training under the supervision and instruction of doctors or hospital employees. These persons may also observe care given to the patient by doctors and hospital employees. I authorize the hospital and my physicians to take photographs or other images of me or parts of my body while under the care of the Hospital for use in medical evaluation, education, or research. Photographs shall be redacted to the extent that the patient cannot reasonably be identified.

PHOTOGRAPHS/DIGITAL MONITORING: I consent to photographs and digital monitoring as appropriate to document specific care (example, but not limited to: an open wound). I understand that photos will be stored in a confidential and secured manner and that I may view and/or obtain copies. I understand that I, or my designated other, will be informed if photos are indicated and that I may refuse to have photos taken. I understand that photos will not be released without my written authorization.

CONDITIONS OF ADMISSION AND TREATMENT

RELEASE OF INFORMATION: The patient agrees that the hospital may disclose all or any part of the patient's medical record and/or hospital charges (including information regarding alcohol or drug abuse, psychiatric illness or communicable disease related information including HIV to any person corporation (1) which is or may be liable or under contract to the hospital for reimbursement on this admission and/or hospital service, including but not limited to hospital/medical service companies, worker's compensation carriers, welfare funds, governmental agencies and (2) any health care provider for continued patient care. The hospital may also disclose on any anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, and medical research for the collection of statistical data or pursuant to State or Federal law statute or regulations. Except as above, and including HIV test results, the hospital will require the patient's written consent to release information about the patient. The patient agrees that in all instances, the original medical records (including x-rays and pathology slides) remain the property of the hospital.

VALUABLES: I acknowledge that I have been instructed to send home personal belongings, valuables and currency, including credit cards. I also acknowledge that I have been informed that HonorHealth has a safe for small valuable such as jewelry and currency and that it is MY responsibility to request use of the safe for such items. I understand that valuables not picked up in 90 days of discharge will be disposed of by HonorHealth without further liability or responsibility. I also understand that HonorHealth is not responsible for the theft or loss of any valuables that I keep in my possession. Dentures, eyeglasses and hearing aids that are in the custody or control of HonorHealth will be reimbursable of no more than $500 but only if such items are in the custody or control of HonorHospital.

ACKNOWLEDGEMENTS: I hereby certify that I have received the following documents titled Notice of Privacy Practices, Information concerning the Advance Directive, Information on HIV, Notice of Program Accessibility, HonorHealth Nondiscrimination Policy Smoking Cessation and Important Notification Concerning Physicians.

Patient Initials: _____

CONDITIONS OF ADMISSION AND TREATMENT

The UNDERSIGNED certifies that he/she has read the items on this form receiving a copy thereof, and is the patient or is duly authorized by the patient's general agent understands this document and herby executes and agrees with the above and accepts its terms.

Patient Signature: _____

Patient Signature, Parent of Minor Child, Court-Appointed Guardian, Patient-Appointed Agent, Statutory Surrogate Spouse

Witness Signature: _____

Second Witness for Telephone Consent: _____

CHANGES TO THIS FORM: The Hospital personnel handling the Patient's admission to the hospital does not have authority to agree to any changes to the Conditions of Admission form.