WAVERLY HEALTH CENTER

Conditions of Admission

Patient Name:_____ **Birth Date:**_____

Medical Treatment: I permit my health care provider, the Clinic, its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, examinations, photographs, and medical treatment.

Practice of Medicine: I understand medicine is not an exact science and that diagnosis and treatment may involve risks. I realize no guarantees have been made to me as to results of examination or treatment at the Clinic.

Photos at Time of Registration: I understand and consent to the clinic staff obtaining my photo to be placed in the electronic medical record at time of registration where cameras have been installed or where applicable.

Special Procedures/Surgery Consent: I am aware, except in emergency situations, that any substantial procedures/surgery shall be explained to my satisfaction by my health care provider or other health professionals. I have the right to consent or refuse consent to such procedures. If the procedure is of an experimental nature, I will have full knowledge.

Ambulance Transfer for Medicare Patients: I understand that if I am required to be transferred to a hospital by ambulance, Medicare will pay for transfer to the nearest hospital that is able to provide the services I need. If I am transferred to a hospital further away, I will be responsible to pay for the portion of the ambulance charges that are not covered by Medicare.

Medical Staff and Student Participation: I understand that the health care providers serving patients including: radiologists, pathologists, anesthetists, and the like, may not be hospital employees but independent contractors and may bill me separately. I realize that among those attending patients at this clinic are health care personnel in training, who unless requested otherwise, may be present during patient care as a part of their education. Observation, pictures, or closed circuit monitoring of patient care may be used for educational purposes unless a patient requests otherwise.

Release of Information: The Clinic may disclose all or part of my medical record to any person or corporation which may be liable under a contract to the Clinic, myself, a family member, or my employer for all or part of the clinic's charge. This includes, but is not limited to: the Industrial Commission, workers' compensation carriers, self-insured organizations, mutual hospital associations, insurance companies, Medicare and its agents, and utilization review or managed care organizations. The Clinic may disclose my records from today to my primary health care provider for continuing health care services. I authorize the Clinic to share information about my immunizations with the Immunization Registry Information System (IRIS) through the Iowa Department of Public Health.

Insurance and Payment Data: Patients are responsible for all charges incurred at the Clinic. Your health insurance will be considered the primary insurer. Treatments, procedures, and other needed services and supplies will be submitted to your health insurance company with your signed consent. The guarantor, normally a parent or guardian for students, will receive an itemized bill from the Clinic for co-payments, deductibles and other charges. A copy of your insurance card is required at check-in. If you belong to an HMO, be aware of restrictions and limitations for medical or pharmaceutical services outside of your HMO territory.

Assignment of Insurance Benefits/Financial Agreement: I authorize payment of my insurance benefits directly to the Clinic for the services provided during my clinic visits. I understand I am financially responsible to the Clinic for all charges, whether they are covered by my insurance or not.

External Medication History: I understand my health care provider may need to perform an external medicine history check to identify all prescriptions that I have currently or have had in the past.

Acknowledgment of Patient Rights:

_____ I acknowledge that I have been offered a copy of "Your Rights and Responsibilities as a Patient" and that I may receive a copy upon
Initials request.

Acknowledgment of Receipt of Privacy Notice: My signature on this form constitutes my acknowledgement that I have been offered a copy of the Notice of Privacy Practices, which describes how my health information is used and shared.

This form has been explained to me and I understand its contents.

Date	Time	Patient Signature
Date	Time	Patient's Agent or Representative Signature — Relationship to Patient
Date	Time	Witness Signature

Patient did not sign admission for the following reason: □ Minor □ Physically Unable □ Has Legal Guardian

Monitored Telephone Call

Person Called:_____ Relationship: _____

Consent Obtained: □ Yes □ No Date:_____ Witness to Phone Call: _____

Person Making Call:_____ Signature: _____