Clinton Regional Hospital

Acknowledgement of Receiving the Conditions of Admission and Authorization for Medical Treatment, the Patient's Rights and Responsibilities, and Notice of Privacy Practices for Clinton Regional Hospital

Conditions of Admission and Authorization for Medical Treatment

I, the undersigned, as the patient or legal agent of the patient, hereby certify I have read, and fully and completely understand this Conditions of Admission and Authorization for Medical Treatment, and that I have signed this authorization knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

Patient's Rights and Responsibilities (Patient Self Determination Act)

I have been furnished information regarding Advance Directives (such as durable power of attorney for healthcare and living wills). I have also been furnished with written information regarding patient rights and responsibilities and other information related to my stay.

*** TELEPHONE CONSUMER PROTECTION ACT (TCPA): "You agree, in order for us to service your account or to collect any** account or to collect any amounts that you may owe us, we may call you at any phone number associated with your account, including wireless numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that 'your office or agent' may contact me as described above."

*****Please initial or place a mark next to the statement that is applicable to you.*****

☐	**I executed an Advance Directive and have been requested to supply a copy to the hospital**	☐	**I have not executed an Advance Directive, wish to execute one and have received information on how to execute an Advance Directive**	☐	**I have not executed an Advance Directive and do not wish to execute one at this time**

Notice of Privacy Practices

I acknowledge that I have received the hospital's Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and and permitted uses and disclosures. I understand that I may contact the hospital Case/Risk Manager or Privacy Officer designated on the notice if I have a question or compliant.

Patient / Authorized Representative Signature: **X** *****If you are not the patient please identify your relationship to the patient.** **(Select relationship(s) from list below):** ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Friend ☐ Sibling ☐ Healthcare Power of Attorney Other (please specify):	**Witness Signature and Title:** **X** **Date:** **Time:** **Additional Witness Signature and Title:** ***Required for patients unable to sign without a representative or patients who refuse to sign.* **X**