ADVANCE DIRECTIVE
ACKNOWLEDGEMENT

PATIENT NAME: JOHNSON, HAZEL SHIRLEY

MEDICAL RECORD NO: M200166

ACCOUNT NUMBER: V023412018

DATE OF BIRTH: 09/05/32

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

Place your initials after <u>each</u> statement.

1. I have been given written materials about my right to accept or refuse medical treatments. _____ (Initialed)
2. I have been informed of my rights to formulate Advance Directives. _____ (Initialed)
3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. _____(initialed)
4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my care givers to the extent permitted by law. _____ (Initialed)

PLEASE CHECK <u>ONE</u> OF THE FOLLOWING STATEMENTS:

☒ **I HAVE** executed an Advance Directive.

☐ **I HAVE NOT** executed an Advance Directive.

☐ **I REQUEST ADDITIONAL INFORMATION** or a referral for assistance to execute an Advance Directive

☐ I have provided a copy of my Healthcare Directive for the medical chart.

☐ Scanned: Date: _____

Mary Jean Parvin
PATIENT OR REPRESENTATIVE SIGNATURE.

3-14-12
DATE

Samara G
WITNESS

3-14-12
DATE

FOR OFFICIAL USE ONLY
☐ REFERRAL MADE
TO:

Lodi Memorial Hospital

975 S. Fairmont Ave. * P.O. Box 3004 * Lodi, California 95240 * (209)334-3411

Patient Name: JOHNSON, HAZEL SHIRLEY
Patient ID Number: V023412018 M200166
Physician: Freund, Edmund MD-Mills Freu

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (HSAG) listed here Health Services Advisory Group 1-800-841-1602.

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (HSAG). Health Services Advisory Group is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
    - **If you want to appeal, you must contact the HSAG no later than your planned discharge date and before you leave the hospital.**
    - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling HSAG and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call the Utilization Management Department 1-800-323-3360 ext 7564.

Please sign and date here to show you received this notice and understand your rights.

Mary Jean Paven, Sister
Signature of Patient or Representative

3-14-12
Date

Delivery of discharge notice:

Date

CMS-R-193 (approved 05/07)

Patient Responsibilities

As a patient of Lodi Memorial Hospital, you have the responsibility to:

a. Maximize healthy habits, such as exercising, not smoking, and eating a healthy diet.

b. Provide, to the best of your ability, accurate and complete information about your present medical issues, past illnesses, hospitalizations, medications, perceived risks in your condition, and other matters related to your health.

c. Work together with healthcare providers in developing an agreed upon plan of care.

d. Follow the treatment plan. Tell your doctor or nurse if you believe you cannot follow through with the treatment plan and why you cannot.

e. Find out about consequences of refusing treatment or of selecting an alternative treatment not recommended by your medical team. Accept the consequences if you do not follow your care plan.

f. Ask questions when you do not understand your care, treatment, or services provided to you, or what you are expected to do.

g. Alert nursing staff to any extra needs you have including meal service, medications, and other treatments.

h. Keep Lodi Memorial Hospital equipment in the building at all times and having licensed staff maintain it, for your safety.

i. Be considerate of Lodi Memorial Hospital staff and other patients and their property.

j. Follow Lodi Memorial Hospital rules and regulations affecting your care and conduct, including but not limited to: visitation, NO smoking policy and assisting our efforts to limit noise.

k. Use Lodi Memorial Hospital's internal complaint and appeal processes to address concerns that may arise.

l. Avoid knowingly spreading disease. Check with your doctor or nursing staff if you are permitted to move about. Stay within your nursing staff surveillance. This is important in achieving the necessary care for your treatment plan.

m. Promptly meet your financial obligations.

n. Provide a copy of an Advance Directive (i.e. Living Will or Power of Attorney for Health Care) if you have completed one.

o. Safeguard your personal belongings by sending your valuables home with family or friends or secure any valuables in Lodi Memorial Hospital's safe, as needed, to prevent loss.

p. Keep scheduled appointments and notify the appropriate department and/or professional when unable to keep an appointment.

JOHNSON,HAZEL SHIRLEY
V023412018 M200166

PATIENT RIGHTS

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.

3. Know the name of the licensed health care practitioner acting within the scope of his or her professional licensure who has primary responsibility for coordinating your care, and the names and professional relationships of physicians and nonphysicians who will see you.

4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication and to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or nontreatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of members of the medical staff, to the extent permitted by law.

7. Be advised if the hospital/licensed health care practitioner acting within the scope of his or her professional licensure proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

8. Reasonable responses to any reasonable requests made for service.

9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.

10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

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13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.

14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information also.

17. Know which hospital rules and policies apply to your conduct while a patient.

18. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
    - No visitors are allowed.
    - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    - You have told the health facility staff that you no longer want a particular person to visit.

    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors. The health facility must inform you (or your support person, where appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.

20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.

21. Exercise these rights without regard to sex, race, color, religion, ancestry, national origin, age, disability, medical condition, marital status, sexual orientation, educational background, economic status or the source of payment for care.

22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or by calling: Lodi Memorial Hospital, 975 S. Fairmont Ave., Lodi, CA 95240, 800-876-6750, ext. 7560. The grievance committee will review each grievance and provide you with a written response within seven days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO).

23. File a complaint with the California Department of Public Health regardless of whether you use the hospital's grievance process. The California Department of Public Health's phone number and address is: California Department of Public Health, 3901 Lennane Dr., Ste. 210, Sacramento, CA 95834, 800-554-0354.

This Patient Rights document incorporates the requirements of the The Joint Commission; Title 22, California Code of Regulations, Section 70707; Health and Safety Code Sections 1262.6, 1288.4, and 124960; and 42 C.F.R. Section 482.13 (Medicare Conditions of Participation).

JOHNSON, HAZEL SHIRLEY
M200166 V023412018

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact HSAG no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for HSAG:
    _____ **HSAG** _____
    _____ **1-800-841-1602** _____
  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting HSAG.
  - The name of this hospital is Lodi Memorial Hospital - 050336__.
- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3**: HSAG will ask for your opinion. You or your representative need to be available to speak with HSAG, if requested. You or your representative may give HSAG a written statement, but you are not required to do so.
- **STEP 4**: HSAG will review your medical records and other important information about your case.
- **STEP 5:** HSAG will notify you of its decision within 1 day after it receives all necessary information.
  - If HSAG finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If HSAG finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after HSAG notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask HSAG or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call HSAG listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:
For more information you are requested to contact Lodi Memorial Hospital Utilization Management Department at 1-800-323-3360 ext 7564 or direct 209 339-7564.

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1. GENERAL ADMISSION CONSENT TO CARE

The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis. They may include, but are not limited to, emergency services, laboratory procedures, x-ray examinations, anesthesia, therapies, medical or surgical treatment procedures, rendered the patient under the instruction of the treating physician. The hospital provides clinical training programs for several categories of health professionals. The programs include allowing students to observe and, in some instances provide nursing or medical assistance under the direction of a physician or hospital staff.

The hospital provides only general duty nursing care unless, upon orders of the treating physician, the patient is to be provided more intensive nursing care. If the patient's condition is such as to need the services of a special duty nurse, it is agreed that such nursing services must be arranged by the patient or his/her legal representative. The hospital shall in no way be responsible for failure to provide the same and is hereby released from any and all liability arising from the fact that said patient is not provided with such care.

2. LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN

All physicians and surgeons furnishing services to the patient, including emergency doctor, on call specialists, radiologist, pathologists, anesthesiologist and the like, are independent medical practitioners with the patient and are not employees or agents of the hospital. Patients may also receive separate bills from the above mentioned independent practitioners or ambulance services. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or the hospital services rendered the patient under the general and special instructions of the physician.

3. PHOTOGRAPHY FOR VARIOUS REASONS

I consent to the taking of pictures of my medical or surgical condition or treatment, and the use of the pictures, for purposes of my diagnosis or treatment or for education or training programs conducted by the hospital.

4. PHOTOGRAPHY OF NEWBORNS

I consent to the taking of photographs of my newborn child or children for possible purchase by me.

5. RELEASE OF INFORMATION

Upon inquiry, the hospital may make available to the public certain basic information about the patient, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning, or other condition), general nature of the injury, burn, poisoning or other condition, and general condition. If the patient or the patient's legal representative does not want such information to be released, he/she must make a written request for such information to be withheld. The patient or the patient's legal representative may obtain a separate form for this purpose upon request.

The hospital will obtain the patient's consent and his/her written authorization to release information, other than basic information, concerning the patient, except in those circumstances when the hospital is required by law to release information.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the hospital and the physicians specifically associated with the patient's medical care, may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the hospital charges, including but not limited to insurance companies, health care service plans or worker's compensation carriers. Special permission is needed to release this information when the patient is being treated for an emotional, drug, or alcohol related problem, or has been tested for immunity to the human immunodeficiency virus (HIV).

6. FINANCIAL AGREEMENT

If the undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the hospital in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees, court costs, at trial or appellate level, and collection expenses. I hereby consent that any credit balance on my account resulting from an overpayment may be applied to other patient accounts for which I am guarantor.

7. THIRD PARTY LIABILITY/AND BILLING

If this service is for treatment of an injury, illness or condition which may have been caused by a third party, for which that third party is, or may be liable for damages, the patient agrees to give the hospital a lien, up to the amount of the outstanding charges, on any recovery the patient makes from the third party, the third party's insurance company, the third party's employer, the third party's guarantor or the third party's principal, or from any uninsured motorist coverage of the patient, the patient's parents, patient's spouse, or the patient's guardian. The patient further agrees that if there is no third party recovery or recovery from uninsured or underinsured motorist coverage, the patient is still personally responsible for payment of the outstanding charges.

8. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of any insurance benefits otherwise payable to or on behalf of the undersigned for this hospitalization or for these outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's regular charges. It is agreed that payment to the hospital, pursuant to this authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this agreement.

9. HEALTH CARE SERVICE PLAN OBLIGATION

This hospital maintains a list of all the care service plans with which it currently contracts. A list of such plans is available upon request from the finance office. This hospital has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by the hospital if he/she belongs to a plan which does not appear on the above mentioned list. When a patient's record is reviewed by the Utilization Review Nurse, or Case Manager, and it is determined that his/her stay is **not medically necessary**, he/she will be responsible for additional charges beyond approved days.

10. PERSONAL VALUABLES

it is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, dentures,. clothes, glasses, hearing aides, etc. unless deposited with in the hospital for safekeeping. The liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited by California Civil Code Section 1860 to $500, unless a written receipt for a greater amount has been obtained from the hospital by the patient. Initial

MEDICARE PATIENT'S CERTIFICATION, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVII 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/or the Medicare Program or its intermediaries or carriers or to the Professional Standards Review Organization any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Medicare Patients - If your physician is admitting you to the hospital for "Observation" it will be considered an outpatient service and will be paid by Medicare as an outpatient (Part B) service.

I have received the ***"Smoking Cessation"*** brochure. This facility is ***"Smoke Free, no smoking allowed."***
I have received the ***"Admissions and Payment Guide"*** brochure.
I have received ***"Your Right to Make Decisions about Medical Treatment"*** brochure.
I have received ***"An Important Message from Medicare"*** and understand my rights as outlined in this document.
I have received the ***"Notice of Privacy Practices"*** brochure.
I have received the ***"Patient Rights"*** document and have verified my personal information.

I have been actively encouraged on how to report concerns related to care, treatment, services, and patient safety issues by calling the Quality Services Response Line (209 339-7400) as well as directly reporting to the Hospital Administration (209 339-7560), the California Department of Public Health Services (916 558-1784) or the Joint Commission hotline at (800-944-6010).

By signing below the patient and/or responsible party indicate that they have read the agreement, clarified any doubts as to its meaning and consent to be legally bound by all of its terms and implementation and have received a copy.

Mary Jean Farrow
PATIENT/PARENT/GUARDIAN/CONSERVATOR

Sister
IF OTHER THAT PATIENT, INDICATE RELATIONSHIP

Sahhary G. 3/14/12 @ 0545
WITNESS *DATE* *TIME*

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, and Assignment of Insurance Benefits.

PARENT/GUARDIAN/CONSERVATOR

I, the undersigned am requesting a private room with full knowledge that I am responsible for charges not covered by my medical insurance.

PATIENT/PARENT/GUARDIAN/CONSERVATOR