Pat. Instr. Signature Page 6-29-14

Lodi Health

Lodi Memorial Hospital

975 S. Fairmont Ave, Lodi CA 95240
(209) 334-3411

Date: 06/28/
Account No: V025938127
Unit No: M053082
Patient: PARVIN,MARY JEAN
Location: 4S
Physician: Ali,Nazish Nawaz MD

Patient Instructions Signature Page

Patient Name: PARVIN,MARY JEAN

Guardian Name:

The above-named patient and/or guardian has received the following patient instructions:

Heart Failure, Heart Failure, Heart Healthy Diet, Heart Healthy Diet

on this date: 06/29/14 - 0238

I have read and understand the instructions given to me by my caregivers.

PARVIN,MARY JEAN

Print Patient Name

Patient or Guardian Signature

Date

Caregiver/RN, Doctor Signature

Date 6/28 6/29/14

7/12

Lodi Memorial Hospital
975 S. Fairmont Ave.
Lodi, CA 95240
(209)334-3411

Patient Name: PARVIN,MARY JEAN Rm/Bed: 4S-466- MR#: M053082
Age/Sex: 71 F Adm Date: 06/28/14 at 1522 Acct#: V025938127
Attend MD: Ali,Nazish Nawaz MD -HOSP

Patient Belongings

PATIENT BELONGINGS----------To be completed upon admission, room change and discharge

Received patient from: Emergency Room Does patient have belongings? Y

Glasses? N Disposition-
Contact lenses? N Disposition-
Purse/wallet? N Disposition-
Medications? N Disposition-
Hearing aid(s)? N Disposition- Side:
Dentures? N Disposition- Type:
Mobility aid(s)? N Disposition- Type-
Prosthesis? N Disposition- Type-
Clothing? Y Disposition- With patient Type- Pants
Shirt
Underwear, socks
Shoes
Jewelry? Y Disposition- Type/ yellow metal cross
yellow metal ring with blue stone, yellow and gray metal watch

Does this inventory match the previous list? N If not please describe action taken
Comment/ jewelry notlisted previously
Discharged to-

06/28/14 MORRIS,TAMI CNA
Electronically completed by the user listed above.

As a patient, I am encouraged to leave personal items at home. It is my responsibility to inform nursing staff when adding or deleting items from the patient belonging inventory list. The hospital is not liable for the loss or damage to any money, jewelry, documents, or other articles that are not placed in the safe. Hospital liability for loss of any personal property deposited with hospital for safekeeping is limited by law to five hundred ($500) unless I receive a written receipt for a greater amount from the hospital.

Family representative taking belongings home_____ Date 6-28-14

Patient/Significant Other Signature:_____

Staff Signature: Tami Morris

Transferred to:_____ Reconciliation Validated by_____ Date_____

Report Name: NUR.PC.WORK.zcus.prt.pl.pt.belongings.R

7/10

Lodi Memorial Hospital
975 S. Fairmont Ave.
Lodi, CA 95240
(209)334-3411

Patient Name: PARVIN,MARY JEAN Rm/Bed: 4S-466- MR#: M053082
Age/Sex: 71 F Adm Date: 06/28/14 at 1522 Acct#: V025938127
Attend MD: Ali,Nazish Nawaz MD -HOSP

Patient Belongings

PATIENT BELONGINGS----------To be completed upon admission, room change and discharge

Received patient from: Emergency Room Does patient have belongings? Y

Glasses? N Disposition-
Contact lenses? N Disposition-
Purse/wallet? N Disposition-
Medications? N Disposition-
Hearing aid(s)? N Disposition- Side:
Dentures? N Disposition- Type:
Mobility aid(s)? N Disposition- Type-
Prosthesis? N Disposition- Type-
Clothing? Y Disposition- With patient Type- Pants
Shirt
Underwear, socks
Shoes
Jewelry? Y Disposition- Type/

Does this inventory match the previous list? Y If not please describe action taken
Comment/

Discharged to- ARBOR

07/10/14 BRAMASCO,JUANITA CNA
Electronically completed by the user listed above.

As a patient, I am encouraged to leave personal items at home. It is my responsibility to inform nursing staff when adding or deleting items from the patient belonging inventory list. The hospital is not liable for the loss or damage to any money, jewelry, documents, or other articles that are not placed in the safe. Hospital liability for loss of any personal property deposited with hospital for safekeeping is limited by law to five hundred ($500) unless I receive a written receipt for a greater amount from the hospital.

Family representative taking belongings home Mary Jean Parvin Date 7-10-14

Patient/Significant Other Signature: _____

Staff Signature: J Bramasco

Transferred to: _____ Reconciliation Validated by _____ Date _____

Report Name: NUR.PC.WORK.zcus.prt.pl.pt.belongings.R

Lodi Health

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Lodi, California 95240
209.334.3411
lodihealth.org

CONDITIONS OF ADMISSION/REGISTRATION

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, telemedicine, therapies, medical or surgical treatment procedures, that are rendered to 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.
2. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN:** Many physicians and surgeons furnishing services to the patient, including emergency doctors, on call specialist, radiologist, pathologist, 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.
   Pt initials_____
   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. **PHOTOGRAPH FOR VARIOUS REASONS:** I, the undersigned, consent to the taking of photographs 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, the undersigned, consent to the taking of photographs of my newborn child or children for purchase by me.
5. **MATERNITY PATIENTS:** If I deliver an infant while a patient of this hospital, I agree these same Conditions of Admissions also applies to the infant(s).
6. **CHILD SAFETY ALERT:** As of January 1, 2012, all children younger than eight years old or under four feet nine inches in height, must be secured in a car seat or booster seat. In addition, all children younger than eight years must be secured in the back seat.
   Pt/responsible party initials_____
7. **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's legal representative does no 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, or other basic information concerning the patient, except in those circumstances when the hospital is required by law to release information.

PARVIN, MARY JEAN

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7. (cont.)
The undersigned agrees 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 but not limited to his/her medical records, to any person or entity 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, government entities 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).

8. **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 full charges billed by 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, the undersigned, 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.
Pt initials_____

9. **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 and hereby does 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 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.
Pt initials_____

10. **HEALTH CARE SERVICE PLAN OBLIGATION:** The hospital maintains a list of all the health care service plans with which it currently has comprehensive written contracts. A list of such plans is available upon request from the Finance office. 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 that does not appear on the above mentioned list and/or if a plan on the list does not pay as required by that plan's comprehensive written contract with the hospital, to the full extent permitted by law. If a patient's record is reviewed by a health plan's utilization review nurse or case manager and that plan comes to the opinion that his/her stay was not medically necessary, then you will be responsible for additional charges beyond approved by the plan, to the fullest extent permitted by law.

PARVIN, MARY JEAN

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11. **PERSONAL VALUABLES**: As a patient I am encouraged to leave or send my personal items home, and it is understood and agreed that Lodi Health maintains a safe for the safekeeping of money and valuables, and Lodi Health shall not be liable for the loss or damage to any money or valuables such as: jewelry, documents, eyeglasses, dentures, hearing aids, cells phone, lap tops, other personal electronic devices or articles of clothing, etc. unless deposited with Lodi Health for safekeeping and a receipt is provided. Lodi Health liability for loss of any personal property which is deposited with the hospital for safekeeping is limited by the California Civil Code Section 1760 to $500, unless I receive a written receipt for a greater amount from the hospital.

Pt intials_____

12. **ASSIGNMENT OF INSURANCE BENEFITS/DIRECT PAYMENT**: I hereby assign to the hospital all of my rights, benefits, privileges, protections, claims, causes of action, interests or recovery, to any and all rights, benefits, privileges, protections, claims causes of action, interests, or recovery of any type whatsoever receivable by me or on my behalf arising out of any policy of insurance, plan, trust, fund, or otherwise providing health care coverage of any type to me (or to any other third party responsible for me) for the charges for services rendered to me by the hospital. This includes, without limitation, any private or group health/hospitalization plan, automobile liability, general liability, personal injury protection, medical payments, uninsured or underinsured motor vehicle benefits, settlements/judgments/verdicts, self-funded plan, trust, worker's compensation, MEWA, collective, or any other third-party payor (collectively, "Coverage Source"). I also authorize direct payment to the hospital of all benefits, payments, monies, checks, funds, wire transfers or recovery of any kind whatsoever from any coverage source. I also agree that any payment of any kind(e.g., checks, funds, payments, monies, benefits or recovery for coverage of services by the hospital that is sent directly to me, or to another third party responsible for me) will be sent immediately to the hospital, through whatever means necessary. This includes, without limitation, endorsing over any checks and/or other documents to the hospital. I also agree to assist signing documents requested or needed to pursue claims and appeals, get documents from coverage source, or otherwise to support payment to the hospital. I also understand that I am financially responsible for charges not paid according to this provision, to the full extent permitted by law.

Pt initial_____

13. **AUTHORIZED REPRESENTATIVE**: I hereby authorize and designate the hospital as my authorized representative to act on my behalf with respect to all matters related to all of my rights, benefits, privileges, protections, claims, causes of action, interests or recovery arising out of any policy of insurance, plan trust, fund, or coverage providing health care coverage of any type to me (or to any other third party responsible for me.) This includes, without limitation, filing claims and appeals, receiving all information, documentation, summary plan descriptions, bargaining agreements, trust agreements, contracts and other instruments under which the plan is established or operated, as well as receiving any policies, procedures, rules, guidelines, 3 protocols or other criteria considered by the Coverage Source, in connection with any claims, appeals or notifications related to claims or appeals.

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13. cont.
This includes, without limitation, filing claims and appeals, receiving all information, documentation, summary plan descriptions, bargaining agreements, trust agreements, ontracts and other instruments under which the plan is established or operated, as well as receiving any policies, procedures, rules, guidelines, protocols or other criteria considered by the Coverage Source, in connection with any claims, appeals or notifications related to claims or appeals.

14. **NOTIFICATION:** To report concerns related to care, treatment, services and patient safety issues call the Patient Safety Concern Line, (209)-339-7400)as well as directly reporting to the Lodi Health Administration (209-339-7560), the California Department of Public Health Services (916-558-1784) or the Joint Commission hotline at (800-944-6010).

15. **MEDICARE PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information give by me 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 the Professional Standards Review Organization any information needed for this or a related Medicare Claim. I request that payments of authorized benefits be made on my behalf.

BY SIGNING BELOW, THE PATIENT AND/OR RESPONSIBLE PARTY FOR THE PATIENT INDICATES THAT THEY HAVE READ THE AGREEMENT AND CONSENTS TO BE LEGALLY BOUND BY ALL OF ITS TERMS AND IMPLEMENTATION AND HAS RECEIVED A COPY OF THIS AGREEMENT.

Pt unable to sign
Patient/Surrogate Decision Maker Signature Date Time Relationship

Witness 7/1/14 852 PAR
Date Time Title

Outpatient forms I have received:
- ☐ Patients Rights document
- ☐ Notice of Privacy Practices
- ☐ ED patients: Your right to make decisions brochure

Inpatient/Observation forms I have received:
- ☐ Admissions and Payment Guide Brochure
- ☐ Patient Responsibility

Medicare/Medicare risk patients:
- ☐ Inpatient notice of Discharge and Medicare Appeal Rights
- ☐ Medicare Observation patient- 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