



Kaiser Foundation Hospital  
Manteca / Modesto Medical Center

### EMERGENCY DEPARTMENT CONSENT TO TREAT

KAISER FOUNDATION HOSPITAL  
ANDERSON, TIFFANY K

MR #: 110007897964

08/22/70

Name:

ENGLISH NO  
AC32068153151

IMPRINT AREA

Please read and sign the following agreement so that we may proceed with the care and treatment ordered by your physician.

- 1. CONSENT TO MEDICAL CARE:** The undersigned hereby consents to the procedures that may be performed during this emergency department visit, including emergency services, which may include but are not limited to laboratory procedures, X-ray examinations, nursing care, medical or surgical treatment or procedures, anesthesia, or other services rendered under the general and special instructions of my physicians. The undersigned understands that the hospital must report certain information (e.g., HIV, tuberculosis, and other diseases) about the patient to organizations such as health departments.
- 2. EDUCATIONAL CONSENT:** The hospital is an educational facility participating in the training of physicians, medical students, student nurses, and other health care personnel, and they may participate in the patient's care to the extent deemed appropriate by the medical staff or hospital personnel.
- 3. CONSENT TO PHOTOS:** I consent to the taking of photographs, videotapes, digital or other images of my medical or surgical condition or treatment, and the use of the images, for purposes of my diagnosis or treatment or for the hospital's operations, including peer review and education or training programs conducted by the hospital.
- 4. PERSONAL VALUABLES:** It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital staff shall not be liable for the loss or damage to any money, jewelry, glasses, dentures, documents, furs, or other articles of unusual value and small size unless placed in the safe, and shall not be liable for loss or damage to any other personal property including clothing and electronic devices. The hospital's liability for loss of any personal property deposited with the hospital for safekeeping is limited by statute to five hundred (\$500) unless the patient obtains a written receipt for a greater amount from the hospital.
- 5. FACILITY DIRECTORY:** Hospital staff may disclose the patient's name, room location/telephone number, and general condition to visitors who ask for the patient by name. In addition, we may provide the patient's religious affiliation, if any, to clergy. The patient may object to the disclosure of some or all of this information. In that event, we will not disclose it to visitors or other members of the public. **Any information you wish withheld will be withheld from all visitors, including florists, family, and anyone inquiring about you. Please indicate any information you wish to be withheld from inquiring visitors:**

- Name                                       Telephone Number or Room Location  
 General Condition                       Religious Affiliation

- 6. ADVANCE DIRECTIVE:** Is patient/representative able to respond?  YES  NO  
 Does the patient have an Advance Directive?  YES  NO  
 If YES, location: \_\_\_\_\_

If NO, Advance Directive brochure provided by: \_\_\_\_\_

**THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THIS FORM, HAS RECEIVED A COPY OF IT, AND ACCEPTS AND AGREES TO ABIDE BY ITS TERMS.**

PATIENT / PARENT / GUARDIAN / CONSERVATOR / AGENT SIGNATURE		DATE	TIME
		10-3-11	6:45a

NAME AND RELATIONSHIP	WITNESS SIGNATURE	NAME OR NUID	DATE	TIME
			10-3-11	6:48a





KAISER PERMANENTE

At the bottom of this page are reminders for some preventive services based on Kaiser Permanente's electronic records. If you have on-going health problems or are at high risk for certain diseases, you may need frequent preventive services and should consult your physician. If an appointment is necessary, please schedule it.

KAISER PERMANENTE

PAYMENT RECEIPT

MRN: 1100078977964 Name: ANDERSON, TIFFANY K

Visit Coverage: KFHP 1000

Service Date/Time: 10/3/11 6:48 AM

Service Type: Emergency

Dept: MAN-ED\*\*\*

Payment Date/Time: 10/03/2011 9:54 AM

Amount Received: \$50.00

Source: Credit Card Ref: W421417

Account ID: 32012094168

Advance Directive:

You have paid the above amount toward your total charges for services you will receive today or during this hospital admission. If this does not cover your full financial liability, you will receive a bill for additional charges based on the specifics of your health coverage plan, your included benefits, and the actual services you receive. If you have questions or want more information about your benefits, limitations, exclusions, and charges please call the telephone number on your identification card.

Your health info online. Register at kp.org for a healthier way of life.

PERSONAL PHYSICIAN(S)

GENERAL: JASTI, HYMAVATHY (M.\*OB/GYN PHYSI: OGUNJIMI, ESTHER OLLWAKEM

OB/GYN OTHER: WALKER, KATHRYN GAIL (N.P.)

Return appointment: \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months

You have paid the above amount toward your total charges for services you will receive today or during this hospital admission. If this does not cover your full financial liability, you will receive a bill for additional charges based on the specifics of your health coverage plan, your included benefits, and the actual services you receive. If you have questions or want more information about your benefits, limitations, exclusions, and charges, please call the telephone number on your identification card.



## Your Kaiser Permanente Care Instructions

### Chronic Fatigue Syndrome: After Your Visit

#### Your Care Instructions

Chronic fatigue syndrome can cause you to be so tired and weak that you cannot do your normal activities. Even after you rest, you still may not have your same old energy. Why chronic fatigue syndrome makes you feel so tired is not well understood.

Your doctor can prescribe medicines that can help you ease your symptoms. There are things you can do for yourself, such as making your schedule more flexible, that should help. Many people improve over a few years.

**Follow-up care is a key part of your treatment and safety.** Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

#### How can you care for yourself at home?

- Keep a diary for a week with notes on the times of day when you have energy and when you are tired. See if there is a pattern to how your energy levels change during the day. Try to plan your work, school, and activities around that pattern.
- Resist the desire to do too much when you have energy. If you overdo it, you may get too tired. Then you may be even more tired the next day.
- If you have problems sleeping, try to improve your sleep habits.
  - Go to bed only when you are sleepy, and get up at the same time every day, even if you do not feel rested. This might help you sleep well the next night and after.
  - If you lie awake for longer than 15 minutes, get up, leave the bedroom, and do something quiet, such as read, until you feel sleepy again.
  - Avoid drinking or eating anything with caffeine after 3 p.m. This includes coffee, tea, cola drinks, and chocolate.
  - Make sure your bedroom is not too hot or too cold, and keep it quiet and dark.
  - Make sure your mattress provides good support.
  - Take naps if you need to. Keep them short, no more than 1 hour, and try not to take them late in the afternoon.
- Get light exercise daily. Gentle stretching, light aerobics, swimming, walking, and riding a bicycle can help to relieve your symptoms.
- Eat a healthy diet. You may feel better if you avoid heavy meals and eat more fruits and vegetables.
- Take anti-inflammatory medicines to reduce pain and aches. These include ibuprofen (Advil, Motrin) and naproxen (Aleve). Read and follow all instructions on the label. No one younger than 20 should take aspirin. It has been linked to Reye syndrome, a serious illness.
- Consider joining a support group with other people who have chronic fatigue syndrome. These groups can be a good source of information and tips for what to do to feel better. Your doctor can tell you how to contact a support group.
- Talk with your doctor or counselor if you continue to feel sad or depressed.

#### When should you call for help?

Watch closely for changes in your health, and be sure to contact your doctor if:

- Your fatigue continues to get worse.
- You do not get better as expected.

#### Where can you learn more?

Go to <http://www.kp.org>

Enter **Y494** in the search box to learn more about "Chronic Fatigue Syndrome: After Your Visit."



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ANDERSON, TIFFANY K

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Name: F

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AC32068153151  
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SD  
# 4

**ASSIGNMENT OF BENEFITS &  
NOTICE OF FINANCIAL RESPONSIBILITY**

**ASSIGNMENT OF BENEFITS:** The undersigned, whether signing as a patient or personal representative of the patient, authorizes direct payment to the hospital and the patient's health care providers of any health care coverage benefits otherwise payable to or on behalf of the patient for these outpatient services. Health care coverage benefits include Medicare, Medi-Cal, other governmental health care program benefits, or commercial payors.

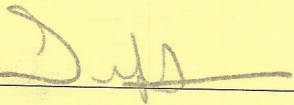
The undersigned authorizes release of medical information necessary to determine eligibility and benefits payable and to submit and process claims for payment.

**FINANCIAL AGREEMENT:** The undersigned, whether signing as a patient, parent, or representative of the patient, agrees to pay all charges for medical and hospital services not otherwise covered by health care benefits, in accordance with the rates and terms of the hospital and medical offices and the patient's treating health care practitioners.

For patients enrolled in a Medi-Cal program, this includes any unmet Medi-Cal Share of Cost obligations and full financial liability for the cost of services for Medi-Cal health care benefits assigned to a non-Kaiser Permanente provider.

If the account is referred to an attorney or collection agency, the undersigned agrees to pay actual collection costs, including attorney's fees, together with interest at the legal rate.

**THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND UNDERSTANDS THIS FORM, AND ACCEPTS AND AGREES TO ABIDE BY ITS TERMS.**

Signature: 

Relationship: Self

Date: 10-3-11