Centura Health®

Patient Label

Hospital Service Agreement

201047

HOSPITAL SERVICE AGREEMENT – PATIENT-HOSPITAL CONTRACT

1. **CONSENT FOR HEALTH CARE SERVICES**. I voluntarily consent to and authorize the rendering of health care services, including routine hospital services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, including the use or potential use of restraint, which my attending physician or others holding clinical privileges consider necessary in person or telehealth. I understand that health care services may be rendered by students, interns or residents under supervision. I further understand that the practice of medicine is not an exact science and I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in this health care facility. I acknowledge Centura Health facilities and providers do not provide medical aid in dying medication or related services. I understand that my rights and responsibilities with regard to my care are described in more detail on the Patient Bill of Rights document.

2. **INDEPENDENT PRACTITIONERS.** I understand that many of the professionals who provide care to me in the hospital are not employees or agents of the Hospital. These professionals may include my own physician, other physicians requested by my physician to participate in my care as well as emergency department physicians, radiologists, pathologists and anesthesiologists. As a result, I understand that these professionals will bill me for charges that are separate from those of the Hospital. I understand that, in some cases these professionals may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance. I understand it is my responsibility for out of network costs or other costs because the professional does not have a contract with my insurance plan. I understand that by entering into this Patient-Hospital Contract, I agree and acknowledge that I have personal financial responsibility for any charges or costs not covered by my insurance, if I have any.

3. **MEDICARE and/or MEDICAID CERTIFICATION**. I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the Hospital on my behalf for the Hospital's and physicians charges for which the Hospital is authorized to bill in connection with these health care services.

4. **RETENTION OF SPECIMENS.** I authorize the Hospital to take, retain, preserve and use for scientific or teaching purposes, or dispose of at its convenience all specimens, tissues, parts or organs taken from my body during my hospitalization.

5. **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I understand this Agreement is a contract and that it obligates me to pay all charges for my treatment not paid by my insurer or any other payer source. I understand the Hospital has pre-determined the charges for certain procedures, supplies, and treatments, which these charges are listed in the Hospital's Chargemaster, and these prices are incorporated by reference into this Contract. I acknowledge it may not be possible to state in advance which specific supplies and services will be part of my treatment. I acknowledge I have the right to receive an estimate of the facility's average charge for treatment that are frequently performed on in-patient, outpatient, or surgical procedures. If I receive an estimate of charges, I acknowledge that the Hospital is acting in good faith by providing such an estimate. I acknowledge that any estimate is not binding and that the charges I am personally obligated to pay may be more than the estimated charge for my specific treatment. I acknowledge this Contract means I personally have full financial responsibility for, and agree to pay, all charges for the Hospital and of physicians rendering services not otherwise paid by my health insurance or other payer based upon the Hospital's pre-determined Chargemaster rates. Estimated patient responsibility is due at the time of service or following the medical screening exam. Any remaining charges are due and payable upon receipt of the bill. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the Hospital.

   If I do not have insurance or I cannot pay my bill, I may qualify for financial assistance. I understand that I may be required to submit documentation to determine my eligibility for financial assistance. I understand the hospital may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 180 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all legal expenses necessary for the collection of any debt or any action on this Contract. I hereby acknowledge and agree that the Hospital has not made any implied representations about the charges I am personally obligated to pay. I understand the charges I will be charged for my treatment are pre-determined rates based upon the Chargemaster in effect at the time of my treatment. I have agreed to pay the Hospital's Chargemaster rates for the treatment I receive.

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6. **COMMUNICATIONS CONSENT.** By providing my cell or other phone number(s), I expressly consent to receive communications from the Hospital, its agents (including any collection agencies) or business associates at any numbers I provide or that are later acquired, to be used to contact me by live agent, voice mail, text message, using an auto dialer or other computer-assisted technology, pre-recorded message, or by any other form of electronic communication for any purpose, including scheduling, notifications, confirmations, reminders, instructions, accounting, billing, assignment of benefits, and/or collections. I understand that depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new numbers if my numbers change. Providing these numbers is not a condition of receiving healthcare services. I consent to be contacted by regular mail or e-mail regarding any matter related to my account by the Hospital or any entity to which the Hospital assigns my account including any collection agency. I also consent to the use of any updated or additional contact information that I may provide by the Hospital or any entity to which the Hospital assigns to my account.

7. **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to obtain all pre-authorization and to comply with all requirements of any insurance or medical/hospital coverage plan upon which I am relying for coverage of the Hospital's and physicians' charges.

8. **ASSIGNMENT FOR DIRECT PAYMENT**. I authorize and direct that payment for any insurance or health care benefits otherwise payable to me for health care services or goods be made directly to the Hospital and my physicians, to include any hospital-based radiologists, pathologists, anesthesiologists and emergency department physicians. I understand that I am financially responsible to the Hospital or my physicians for charges, based upon Chargemaster rates, not covered or paid pursuant to this authorization.

9. **PERSONAL VALUABLES.** The Hospital maintains a safe for the safekeeping of any money or valuables. I understand that the Hospital does not assume responsibility for the loss, damage, or disposal of my personal property or money including jewelry, clothing, dentures, eyeglasses, contact lenses, hearing aids, prosthetic devices, or any other item unless such money or property is deposited with the Hospital. I take full responsibility for any money or property retained in my possession/room or brought to me while I am a patient at the Hospital.

10. _____ ACKNOWLEDGE (Initials) **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Centura Health has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Centura Health's web-site. I understand this acknowledgement in no way affects the care I receive at the Hospital.

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO AND ACCEPT ITS TERMS.

_____ _____ _____

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME DATE TIME

_____

PRINTED NAME OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME

_____

RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN

_____

ADDRESS OF PATIENT

Centura Health®

Patient Bill Of Rights

Patient Rights:
Centura Health Hospitals support the rights of all patients across the lifespan including geriatric, adult, adolescent, pediatric, infant and neonatal populations. These rights may be exercised through the patient individually or through their authorized surrogate decision maker.

You have the right to. . .

1. Be informed of your patient rights in advance of receiving or discontinuing care when possible.
2. Receive care, treatment and visitation regardless of disability, national origin, culture, age, color, race, religion, gender identity, sexual orientation. No one is denied examination or treatment of an emergency medical condition because of their source of payment.
3. Give informed consent for all treatment, procedures, and/or production of recordings, films or other images when used for other than identification, diagnosis or treatment.
4. Be informed of your health status/prognosis, including unanticipated outcomes of care and the treatment and services related to serious preventable adverse events.
5. Participate in all areas of your care plan, treatment, care decisions, and discharge plan.
6. Receive appropriate assessment and prompt management of your pain.
7. Be treated with respect and dignity.
8. Experience personal privacy, comfort and security to the extent possible during your stay.
9. Be free from restraints or seclusion imposed as a means of coercion, discipline, convenience or retaliation by staff.
10. Experience confidentiality of all communication and clinical records related to your care. You will receive a copy of our Notice of Privacy Practices to inform you how your personal medical information can be used and disclosed and your rights related to your medical information.
11. Have access to telephone calls, mail, and other communication devices. Any restrictions to access will be discussed with you, and you will be involved in the decision when possible or appropriate.
12. Choose a “visitor” who may visit you, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and you have the right to withdraw or deny such choice at any time. You also have the right to select an identified “support person” who can make visitation decisions should you become incapacitated.
13. If hospitalized, have the right to designate at least one post-discharge caregiver who will assist you with basic tasks following your discharge and, along with you or your authorized surrogate decision maker, provide consultation on your discharge plan. Designating a post-discharge caregiver does not mean the person you have designated is obligated to care for you.
14. Be communicated with in a manner you can understand which is tailored your age, language, understanding and ability including, but not limited to, access to interpreter services and communication aides, at no cost.
15. Have access to pastoral/spiritual care.
16. Receive care in a safe setting.
17. Be free from all forms of abuse, neglect, mistreatment, or exploitation.
18. Have access to protective services (e.g., guardianship, advocacy services, and child/adult protective services).
19. Request medically necessary and appropriate care and treatment.
20. Refuse any drug, test, procedure, or treatment and be informed of the medical consequences of such a decision.
21. Consent to or refuse to participate in teaching programs, research, experimental programs, and/or clinical trials.
22. Receive information about Advance Directives. Set up or provide Advance Directives and have them followed. Designate an authorized surrogate decision-maker as permitted by law and as needed.
23. Participate in decision-making regarding ethical issues, personal values or beliefs.
24. If hospitalized, have a family member or representative of your choice and your physician promptly notified of your admission to the hospital, upon request.
25. Know the names, professional status and experience of your caregivers.
26. Have access to your medical records within a reasonable timeframe.
27. Be examined, treated, and if necessary, transferred to another facility if you have an emergency medical condition or are in labor, regardless of your ability to pay.
28. Request and receive, prior to the initiation of non-emergent care or treatment, the charges (or estimate of charges) for routine, usual, and customary services and any co-payment, deductible, or non-covered charges, as well as the facility’s general billing procedures, including receipt and explanation of an itemized bill. This right is honored regardless of the source(s) of payment.

29. Be informed of the hospital's complaint and grievance procedure and whom to contact to file a concern, complaint or grievance.
    Note: If you have financial issues or questions, please contact Centura Consumer Operations at (303) 715-7000. Toll free: 888-269-7001
    a. Our priority is for you to have a positive patient experience. If your concerns are not being resolved with your immediate care giver or the department manager or administrative staff, please call the Patient Care Representative/Advocate or access the hospital operator by dialing "0".
    b. You may also contact The Health Facilities Division of the Colorado Department of Public Health and Environment or the Kansas Department of Health and Environment and the Office of Civil Rights directly regardless of whether you first used the hospital's complaint and grievance process.

    The Colorado Department of Public Health and Environment
    4300 Cherry Creek Drive South Denver, CO 80222-1530
    Telephone: (303) 692-2827

    The Kansas Department of Health and Environment
    1000 SW Jackson, Topeka, Kansas 66612
    Telephone: (785) 296-1500

    The Office for Civil Rights
    Department of Health and Human Services
    999 18th Street, South Terrace, Suite 417
    Denver, Colorado 80202
    Telephone: 303-844-2024
    TDD 303-844-3439
    Fax: 303-844-2025

    Office of Civil Rights Procedures are located on facility webpages. You may also contact the Patient Representative.

    c. If you received care in a hospital, emergency department, home care or hospice and if after speaking with one of their representatives your complaint remains unresolved, you may contact The Joint Commission:

    The Joint Commission
    Division of Accreditation Operations, Office of Quality and Patient Safety
    One Renaissance Boulevard
    Oakbrook Terrace, IL 60181
    Telephone: 1-800-994-6610
    E-Mail: complaint@jcaho.org
    Fax: (630) 792-5636.

You also have the right to file a complaint with the appropriate oversight boards including the Colorado Board of Medical Examiners, the Colorado Dental and Podiatry Boards and the Colorado Department of Regulatory Agencies. For Kansas hospitals, this includes the Kansas State Board of Healing Arts, the Kansas Board of Nursing and the Kansas Office of Health Occupations Credentialing. Contact information will be provided by a facility representative upon request.

Patient Responsibilities:
You have the responsibility to . . .

1. Ask questions and promptly voice concerns.
2. Give full and accurate information as it relates to your health, including prescription and non-prescription medications.
3. Report changes in your condition or symptoms, including pain, and request assistance of a member of the health care team.
4. Educate yourself. Learn about the medical tests that are being performed and understand your treatment plan.
5. Follow your recommended treatment plan.
6. Be considerate of other patients and staff.
7. Secure your valuables.
8. Follow facility rules and regulations.
9. Respect property that belongs to the facility or others
10. Understand and honor financial obligations related to your care, including understanding your own insurance coverage.

_____ I acknowledge that Centura Health has offered me a copy of its Non-Discrimination Statement. I understand that the Statement is also available to me as a handout if I choose, and is also electronically available on Centura Health's website.

Signature: _____ Date: _____ Time: _____

Centura Health®

Outpatient Fall Risk Tool
CHADM-023 rev. 02/13

Patient Label

Date: _____ Time: _____

Form Completed by: ☐ Patient ☐ Caregiver ☐ Other: _____

Are You At Risk for A Fall?

To ensure your safety at today's visit, please answer the following questions.

Please select an answer for each question:

	Yes	No
1. Have you had a fall in the last 12 months?	☐	☐
2. Are you here because of a recent fall?	☐	☐
3. Do you have difficulty with walking or balance?	☐	☐
4. Do you have a fear of a fall?	☐	☐
5. Do you take medications that may make you dizzy or unsteady?	☐	☐
6. Would you like extra help today to avoid falling?	☐	☐

If the answers to the questions above are NO, no further interventions are needed.

If you answer "Yes" to ANY question you are at risk for falling.

For internal use only

If patient is at risk for falling, see precautionary measures below:

For use within the registration area:
Use a wheelchair for transport (if applicable) patient declined; initial _____
Instruct patient/family to request assistance with mobility
Identify fall risk patient using a yellow wristband/yellow sticker

For use within the treatment area:

i. Equipment safety: i.e. lock all moveable transfer equipment, utilize side rails
ii. Orient patient to surroundings and environment
iii. Instruct patient/family to request assistance with mobility
iv. Assist with transfers and ambulation including wheelchair for transport
v. Identify fall risk patient using a yellow wristband/yellow sticker on chart (per SOP)

St. Anthony Hospital
Centura Health

Patient Label

Outpatient Physical, Occupational, and Speech Therapy Health History Questionnaire
SAH0165TH rev. 01/14

R E H A B

Outpatient Physical, Occupational, and Speech Therapy Health History Questionnaire

Name: _____ Date: _____

How were you referred to our clinic? ☐ Doctor referral ☐ Friend/relative ☐ Other: _____

Past Medical History

Please list any medication you are taking and for what condition: _____

_____

_____

Are you allergic to latex? ☐ No ☐ Yes

Do you have or have you ever had:

☐ Asthma ☐ Cancer ☐ High Blood Pressure ☐ Diabetes ☐ Pacemaker

☐ Heart Disease ☐ Respiratory Disease ☐ Psychiatric Disorders ☐ Seizures

Please list any other medical issues: _____

_____

Please list all previous surgeries with dates (if known): _____

_____

_____

Check if you have difficulty: ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

Please check the way that you learn most effectively: ☐ Seeing ☐ Hearing ☐ Doing ☐ Talking ☐ Pictures

Current History

Date of onset/injury/surgery: _____ Date of next appointment with referring physician: _____

Have you had therapy in the past 12 months? ☐ No ☐ Yes

Describe your injury/onset of symptoms: _____

_____

Please list/describe any other treatment you are receiving for your current condition: _____

_____

What activities are you unable to do, *or have to do differently*, because of your symptoms? _____

_____

What are your goals/expectations for coming to therapy? _____

_____

Do you feel safe at home? ☐ No ☐ Yes

Are you in a relationship where you are being physically or verbally abused? ☐ No ☐ Yes

Outpatient Physical, Occupational, and Speech Therapy Health History Questionnaire
SAH0165TH rev. 01/14

Patient Label

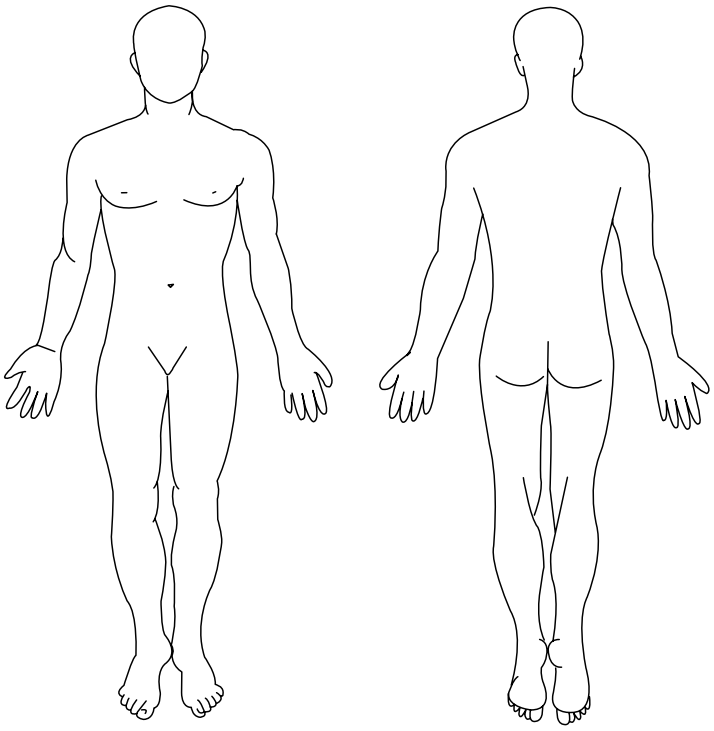
R E H A B

Outpatient Physical, Occupational, and Speech Therapy Health History Questionnaire

Occupation: _____

How would you describe your daily activity level? ☐ Sedentary ☐ Light Physical ☐ Moderate Physical ☐ Heavy Physical

Please shade in the area where you feel your symptoms.



Front **Back**

How intense is your pain?
0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

How frequent is your pain?
0 1 2 3 4 5 6 7 8 9 10
Never Constant

When is your pain the worst?
☐ Morning ☐ Evening ☐ No pattern

Please list any positions or activities which ***decrease*** your pain: _____

_____

_____

_____

Please list any positions or activities which ***increase*** your pain: _____

_____

_____

_____

Do you have any numbness/tingling? ☐ No ☐ Yes If yes, describe where: _____

_____

What makes this better/worse? _____

_____

Patient/Responsible Party Signature **Date** **Time**

Therapist Signature **Date** **Time**

St. Anthony North Health Campus

Centura Health

Attendance Contract

***Thank you* for choosing *St. Anthony North Health Campus*. Keeping scheduled appointments is critically important to the success of your therapy plan of care. Missed appointments impact the outcome of your therapy goals.**
Missed appointments impact other patients who could benefit from the time of the therapist.

- *I (Patient)_____ understand my Plan of Care as developed by the therapist with me and agree to attend my scheduled therapy appointments to accomplish the goals we established.*

- *If I am unable to attend any of my scheduled appointments I agree to cancel my appointment at least **24 hours** in advance of my scheduled appointment.*

- *I understand that if I do not cancel my scheduled appointment 24 hours in advance that it not only impacts my outcomes, but that it takes an appointment time away from another patient being able to see the therapist.*

- *I understand that if I am more than 7 minutes late, my appointment may be rescheduled and may be considered a missed appointment.*

- *I understand that if I miss or cancel 2 appointments during my plan of care that I will be discharged from physical therapy.*

- *I understand that it is my responsibility to inform my therapist of any changes in my health condition or insurance coverage.*

- *Please note we are required to report progress to your referring physician.*

*Patient*_____ *Date:*_____

*Witness:*_____*Date:*_____