Banner Health

CONDITION OF ADMISSION AND TREATMENT

1. **CONSENT FOR HEALTH CARE SERVICES:** I give my consent to all health care services including routine hospital services, procedures, medications, laboratory procedures and tests, injections and other services or procedures given as ordered by my physician/physician extender or as required by hospital procedure. This consent is effective for this inpatient/outpatient visit and for recurring outpatient services of the same type for a period of one year following its execution. This Condition of Admission and Treatment Agreement covers, and I consent to, telemedicine services, including but not limited to e-ICU and consultative services. For obstetrical patients, the consent applies to both the obstetrical patient and the newborn(s). I further understand that a physician is not in the hospital 24 hours/day in the following Banner hospitals: Community Hospital-Torrington, East Morgan County Hospital, Platte County Memorial Hospital, Ogallala Community Hospital, Banner Heart Hospital, Banner Behavioral Health Hospital, and Page Hospital.
2. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND HEALTH CARE PROVIDERS:** The patient will be treated by his/her attending physician, including physician extenders and covering physicians, and be under his/her care and supervision. Physicians and other health care providers furnishing services to the patient, including but not limited to the emergency room physician, hospitalist,radiologist, pathologist and anesthesiologist, are generally not employees or agents of the hospital, and the hospital is not liable for their actions or omissions. These providers may bill separately for their services. Questions about whether a healthcare provider is an agent or employee of the hospital should be directed to Administration during normal business hours, and the Administrator On Call or the Chief Nursing Officer/ Designee after hours, weekends and holidays.
3. **MONEY AND VALUABLES:** Valuables and money should not be brought to the hospital and should be given to family members for safekeeping. The hospital has a safe in which to keep money or valuables. The hospital will not be responsible for loss of or damage to items not deposited in the safe (such as glasses, dentures, hearing aids, contact lens, jewelry or money).
4. **PHOTOGRAPHS/VIDEOS/TAPED THERAPY SESSIONS:** I understand and agree that photographs and/or videos may be taken of me for identification, treatment, security, educational and/or quality improvement purposes. I further agree that all photographs and tapes will remain the property of Banner Health. I will not audiotape, videotape or take pictures of other patients and will not audiotape, videotape or take pictures of Banner Health staff without their permission.
5. **TEACHING PROGRAM:** The hospital participates in training programs for physicians and health care personnel. Some patient services may be provided by persons in training under the supervision and instruction of physicians or hospital employees. These persons in training may also observe care given to the patient by physicians and hospital employees.
6. **RELEASE OF INFORMATION:** The patient acknowledges and understands that the hospital utilizes an electronic record, and that treatment from Banner facilities is integrated into one record. The patient agrees that medical and/or financial records (including information regarding genetics, alcohol or drug abuse, HIV related or other communicable disease related information) may be released without consent to the following:
   A. Health care providers who are providing or have provided health care to the patient; health care providers, including doctors and other care providers, who are contacted for treatment purposes, including providers of post discharge services; any individual or entity responsible for payment of hospital's or other provider's charges; to health care providers or organizations accrediting the facility or conducting utilization review, quality assurance, or peer review; and to the hospital's and provider's legal representatives and professional liability carriers.

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B. Individuals and organizations engaged in medical education and research, provided that information may only be released for use in medical studies and research without patient identifying information.
C. Patient records provided at any contracted Banner facility may be provided to the Consumer Product Safety Commission for the purpose of investigating product related injuries and developing safer products.
D. Individuals and entities as specified by federal and state law and /or in the hospital's Notice of Privacy Practices.

The Release shall continue for so long as the medical and /or financial records are needed for any of the above-stated purposes.

7. **CONTRABAND:** Drugs, alcohol, weapons and other articles specified as contraband by the hospital may not be brought onto the hospital premises. Any illegal substance will be confiscated and turned over to law enforcement authorities. If the presence of contraband is suspected, the patient's room and belongings may be searched, and visitors may be searched before visitation.

ACKNOWLEDGMENTS

I acknowledge receipt of or I have previously received and decline another copy of the:

Initial ☐ **Notice of Privacy Practices for Banner Health / Patient Rights & Responsibilities / Smoking Cessation**

Initial ☐ If applicable in the state where I am receiving care, I acknowledge receipt, and have read and understood the information regarding the State/Regional Health Information Exchange/ CommonWell or I previously received this information and decline another copy.

Initial ☐ I acknowledge that I have been informed about the information to be included in the facility directory and agree to the release of the patient's name, room number, and room phone number except for behavioral health patients to callers and visitors who ask for the patient by name.

AGREEMENT

I have read and understand this Medical Treatment Agreement. I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement.

Patient/Authorized Representative	Relationship
Witness ID Number	Date/Time
2nd Witness Signature (if needed)	