Roundup Memorial
Healthcare

CONDITIONS OF REGISTRATION

CONSENT TO SERVICES

A. **GENERAL DUTY NURSING:** The hospital provides only general duty nursing care. Under this system, nurses are called to the bedside of a patient by a call light signal system. If the patient requires continuous or special duty/one-one nursing care, it is agreed that such care shall be arranged by the patient, or her/his legal representative, or her/his physicians, and 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 additional care.

B. **MEDICAL CONSENT:** I am requesting services to diagnose and/or treat a medical condition. I consent to and authorize RMH to provide care including all diagnostic and therapeutic treatments, including HIV testing, considered necessary or advisable in the judgment of the providers and others participating in my care and treatment. I understand that I am under the care and supervision of my provider. The hospital and its clinical staff are responsible for carrying out my provider's instructions. My provider and care team are responsible for obtaining my specific informed consent for special medical or surgical treatments, special diagnostic or therapeutic procedures, or hospital services needed to diagnose or treat my condition. During the course of receiving health care services, medical imaging may be needed to evaluate the course of my condition or treatment. I acknowledge that video, audio and/or photographs may be taken or produced at the request of my provider or other member of my care team for purposes of my treatment. I also voluntarily consent to HIV, hepatitis or other testing for blood and fluid borne pathogens, if a health care worker or employee is exposed to my blood or other body fluids. In the event that I may need to be transferred to another facility for continued care, I consent to the exchange of any of my protected health information for any purpose between my transferring medical team/entity and receiving or treating medical team/entity.

C. **EMERGENCY TELEMEDICINE SERVICES:** This facility uses telemedicine services via Avera Healthcare. I acknowledge and consent to utilizing telemedicine or other electronic technologies to communicate with other healthcare providers.

D. **PERSONAL VALUABLES:** It is understood and agreed that the hospital maintains a secure location for the safekeeping of money and valuables. RMH shall not be held liable for the loss or damage of any valuables or personal belongings.

E. **FINANCIAL AGREEMENT:** I authorize my insurance company or health plan to pay medical benefits on my behalf directly to RMH. I understand and agree that I remain financially responsible for the payment of all medical services provided to me by RMH, my attending physicians or other health care providers. If RMH is not a participating provider with my health plan, I understand and agree that RMH may choose not to bill my health plan and that I will be billed for all services. I consent to be contacted by regular mail, e-mail, or by telephone (including a cell phone/wireless number/SMS Test Messaging) regarding any matter to my accounts(s), by RMH or any entity to which RMH assigns my account(s). I consent for RMH to use technology, including automated technology such as auto-dialing or pre-recorded messages, to contact me at the address, e-mail, or telephone number, including any cell phone/wireless number, I have provided; or any updated or additional contact information I provide at a later time. This consent applies to all healthcare providers and agents covered under this agreement. I authorize RMH to use or disclose my healthcare information to assist in obtaining reimbursement for services rendered. Payment is due within thirty (30) days from invoice date. A Patient Account Representative is available to discuss payment arrangements or financial programs including financial assistance during normal business hours 8-5 Monday through Friday, except for holidays. If I default or do not pay my bill, I understand and agree that I will pay the full amount owed plus, subject to state and federal law, to pay all costs, attorney fees, expenses, delinquent charges and interest in the event RMH or any entity to which RMH assigns my account(s) has to take action to collect same because of my failure to pay in full all incurred charges within 60 days after receipt of the bill.

I agree to be responsible for any co-payments, deductibles, or other charges of RMH. I further understand and agree, that unpaid portions of my account balance(s) may be subject to a finance charge.

F. **NO GUARANTEE OF CURE:** The undersigned acknowledges that no guarantees have been made as to the result of examination or treatment provided to patient in this hospital, and further understands that she/he is responsible for making arrangements for follow-up care.

G. **PERMISSION TO PUBLISH:** As a patient at RMH, I may choose to be registered as a "VIP status. "VIP" status is defined as the patient does not want others to know they are a patient in the facility. For example; if RMH staff received a phone call asking if John Doe was a patient, RMH staff would say, "I'm sorry, I don't have a patient here by that name". I may change my status at any time. My choice for "VIP" status is indicated by checking a box below:

- ☐ No "VIP" Status. Staff has permission to tell people that I am in the hospital. Initials____
- ☐ Yes "VIP" Status. Staff does NOT have permission to tell people that I am in the hospital. Initials____
- ☐ I understand this does not apply to me because I am a patient in the clinic, not the hospital. Initials ____

H. **CONTACT BY MOBILE PHONE**: By providing RMH with a mobile telephone number, I consent for healthcare related calls and messages to be made to the mobile phone number.

I. **APPOINTMENT OF RMH AS AUTHORIZED REPRESENTATIVE**:
I understand that RMH may assist in pursuing a claim or appeal of a denied claim. I authorize and appoint RMH to act on my behalf and/or on behalf of my covered child/dependent (under 18 years of age) as my authorized representative with any insurance carrier with whom valid insurance coverage exists for medical services. I further direct that any payment made by any insurance carrier as a result of a successful appeal is to be paid directly to RMH. This authorization and appointment will remain valid until such time as I revoke this authorization and appointment in writing to RMH and my insurance carrier(s).

J. **NON-DISCRIMINATION:** RMH is committed to providing care to all persons regardless of type of insurance coverage, race, creed, color, gender, age, national origin, disability, sexual orientation, gender identity or expression.

K. **PATIENT AND VISITOR GRIEVANCE/COMPLAINT PROCEDURES:** A grievance is an actual or supposed circumstance causing distress and regarded as a reason for concern and complaint. It is the policy of RMH to provide an effective means for patients and visitors to communicate issues of concern and to provide a formal procedure to ensure a prompt and equitable resolution of these concerns for the improvement of the facility and satisfaction of our customers.

You may file a verbal or written grievance or complaint without fear of threat or reprisal in any form.

- Obtain a Patient and Visitor Grievance/Complaint Report Form from the nurses' station or any reception area in the facility.
- Answer all questions on the form, as applicable. Be sure the information is accurate.
- Be sure that you sign and date the form. If no signature is present, we will be unable to provide any follow up related to your grievance/compliant.

- Give the completed report form to the Risk Manager (RM) or, if after hours, give to the charge nurse. It will then be placed in a sealed envelope and forwarded to the RM for processing.
- Within ten (10) business days of the date you file the grievance, you will receive a summary of the results from the investigation.
- Should you disagree with the findings, recommendations, or actions taken, you may meet with the administrator or you may file a complaint with the state survey agency (1-800-332-2272 or 406-444-2099).

L. **PATIENT RIGHTS AND RESPONSIBILITIES:**

As a patient of Roundup Memorial Healthcare, you have the right:

- To receive care in a safe setting, free from abuse.
- To receive considerate and respectful care.
- To be well-informed about your illness, possible treatments, likely outcomes, and to discuss freely with your Medical Provider (Physician, Physician Assistant, Nurse Practitioner), and be involved in care planning.
- To know the names and roles of the people involved in your care.
- To consent to, or refuse, any treatment as permitted by law and to know the potential consequences of your decision.
- To have an Advance Directive such as a Living Will, Durable Power of Attorney for Medical Care, and/or Provider Order for Life Sustaining Treatment (POLST). You should provide a copy to the hospital, your primary care provider, and your family.
- To every consideration of privacy and be free of restraints and involuntary seclusion unless medically necessary.
- To expect that treatment records will be kept confidential unless you have given permission to release information or reporting that is required by law.
- To view your medical records and have information explained to you; except when restricted by law.
- To expect that, within the capacity and policy of the hospital; you will receive the necessary health services, treatment, referral or transfer (if recommended). If transfer is recommended or required, you will be informed of the risk, benefits, and alternatives. You must also be accepted by the receiving hospital prior to transfer.
- To ask and be informed of any relationships with educational institutions, healthcare providers or payers that may influence your care and/or treatment.
- To consent or refuse to participate in any research affecting your care.
- To be told of realistic alternatives when hospital care is no longer appropriate.
- To know about hospital rules and policies that may affect you or your treatment as well as charges and payment methods, and be informed of the hospital grievance procedures.
- To be informed of available hospital resources, such as patient representatives or ethics committees, that can help you resolve problems or questions about your hospital stay and care.
- To have a family member, friend and/or your personal physician notified of your admission.

As a patient of Roundup Memorial Healthcare you have the responsibility:

- To follow facility rules affecting your care and conduct.
- To provide a complete and accurate medical history.
- To make it known if you do not understand your plan of care.
- To be considerate of the rights of other patients, facility personnel, and property.
- To provide timely and accurate information concerning your sources of payment and ability to meet financial obligations.

- To cooperate with your Medical Provider (Physician, Physician Assistant, or Nurse Practitioner) and facility staff in their efforts to restore health by maintaining the treatment recommended while in the hospital and after discharge.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

RMH must attempt to have you sign this form on your first date of service with us. If your first date of service was due to an emergency, RMH must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as RMH can after the emergency.

By signing this form, I acknowledge that RMH has informed me that I may receive a copy of RMH's *Privacy Notice* (HIPPA) which explains how my health information will be handled in various situations, *Patient and Visitor Grievance/Complaint Procedures*, and *Patient Rights and Responsibilities*; or, may access them on RMH's website at rmhmt.org. I acknowledge that I, the undersigned, has read and understand the *Conditions of Registration* and accept its terms.

Patient and/or designee:

Printed Name: _____

Signature: _____

Date: ____/____/____ Time: ___:___AM/PM Relationship: SELF Other: _____

☐ Patient unable to sign due to (condition): _____

☐ Patient and/or designee refused to sign: _____

STAFF SIGNATURES

_____ ____/____/____ ___:___ AM/PM
Staff signature Date Time

_____ ____/____/____ ___:___ AM/PM
Witness signature Date Time

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INFORMING INDIVIDUALS WITH LIMITED ENGLISH

Certified Languages Internaltional 1-800-225-5254

e-Emergency Avera 1-877-283-7237

English
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-225-5254/1-877-283-7237.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-225-5254/1-877-283-7237.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-225-5254/1-877-283-7237.

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-225-5254/1-877-283-7237.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-225-5254/1-877-283-7237.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-225-5254/1-877-283-7237.

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-800-225-5254/1-877-283-7237. まで、お電話にてご連絡ください。

Cushite (Somali)
FIIRO GAAR AH: Haddii aad adigu ku hadasho Kuush, adeegyada ka caawinta luqadda ayaad lacag la'aan ku heli kartaa. Wac 1-800-225-5254/1-877-283-7237.

Swahili
KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-225-5254/1-877-283-7237.

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-225-5254/1-877-283-7237.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-225-5254/1-877-283-7237. 번으로 전화해 주십시오.

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-225-5254/1-877-283-

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-225-5254/1-877-283-7237.

Norwegian
MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-225-5254/1-877-283-7237.

Nepali
ध्यान दिनुहोस् : तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-225-5254/1-877-283-7237.

Thai
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-225-5254/1-877-283-7237.