HOAG LUNG CLINIC in the Oncology Specialty Care Clinic

One Hoag Dr | Cancer Center | 3rd Floor | Suite 122 | Newport Beach CA | 92663 | TEL: (949) 764-6166 | Fax: (949) 764-6146

Area Map of Hoag Cancer Center Building

Hoag Hospital and
Hoag Health Center
Newport Beach

N
W
E
S

Entry
Health Center
PA
PB
500
510
520
HOAG HEALTH CENTER
SUPERIOR AVE
DANA RD
PLACENTIA AVE
Imaging Entrance
NEWPORT BLVD (55 FREEWAY)
FLAGSHIP RD
Upper Campus Entry
East Parking
HOSPITAL RD
P8
H
P1
Emergency Department
D
A
Hospital
C
B
WEST HOAG DR
HOAG DR
South Parking
P2
NEWPORT BLVD
E
P4
P3
P7
G
P6
F
P5
SUNSET LOT
PACIFIC COAST HIGHWAY
Lower Campus Entry

Room 107, 3rd Floor

Digestive Disease Center

Room 122, 3rd Floor

Lung Clinic

Melanoma & Advanced Dermatology Clinic

Sarcoma Clinic

CARES Clinic

Medical Oncology Clinic

Hoag Hosp. Dr

hoag

Find Your Destination

HOAG CAMPUS

Destination	Building
Advanced Technology Pavilion	G
Cancer Center	E
Conference Center OB Education Meeting Rooms CC1-CC6	F
Emergency Department	D
Heart & Vascular Institute	B
Heart Valve Center	C
Hospital Main Entrance	A
Neurosciences Institute	F
South Entrance	B
Women's Pavilion	A
307 Placentia Ave Community Medicine	H
East Visitor Parking	P1
South Visitor Parking	P2
Cancer Center Parking	P3 P4
Conference Center Parking	P5
Advanced Technology Parking	P6
Child Care Center	P7
307 Placentia Parking	P8

HOAG HEALTH CENTER

Destination	Building
500 Superior Ave	500
510 Superior Ave	510
520 Superior Ave	520
Parking Structure A	PA
Parking Structure B	PB

P Parking

One Hoag Dr | Cancer Center | 3rd Floor | Suite 122 | Newport Beach CA | 92663 | TEL: (949) 764-6166 | Fax: (949) 764-6146

DIRECTIONS

From the CA- 55 Fwy South

The 55 Freeway ends at 19th Street in Costa Mesa and turns into Newport Blvd. Continue onto Newport Blvd South. Take exit on the **RIGHT** for the CA 1 Ramp (PCH)
Turn **RIGHT** onto the CA 1 North. Then turn **RIGHT** at the first street light called Hoag Hosp. Once you are on Hoag Hosp. make an immediate **RIGHT**. The Advanced Technology Pavilion is on the Left, go past that, and the Cancer Center is on the **LEFT** hand side. Park in the parking lot labeled **P3**, located in front of the Cancer Center building.

From CA-1 (Pacific Coast Hwy) North

Heading North on Pacific Coast Highway go past Newport Blvd. Turn **RIGHT** at the next street light called Hoag Hosp. Once you are on Hoag Hosp. make an immediate **RIGHT** in the driveway. The Advanced Technology Pavilion is on the left, go past that, and the Cancer Center is on the **LEFT** hand side. Park in the parking lot labeled **P3**, located in front of the Cancer Center building.

From CA-1 (Pacific Coast Hwy) South

Heading South on Pacific Coast Highway you will go past Superior Ave. Turn **LEFT** at the next street light called Hoag Hosp. Once you are on Hoag hosp. make an immediate **RIGHT.** The Advanced Technology Pavilion is on the Left, go past that, and the Cancer Center is on the **LEFT** hand side.
Park in the parking lot labeled **P3**, located in front of the Cancer Center building.

Cancer Center Building Directions

Enter the Cancer Center at ground level from the parking lot in front of the building. Use the elevators which are located to left as you walk in the front entrance. Go up to the third floor. Go down the hall on the right when you exit the elevator. Follow the signs for Lung Clinic which is located in the Oncology Specialty Care Clinic. We are the first door on your right in Room 122.

Hoag Family Cancer Institute

CURRENT TREATING PHYSICIAN LIST

Name:		Best Contact Phone #:	
E-mail:		Secondary Phone #:	
Pharmacy:		Pharmacy Phone #:	

Send Records to ✓	PHYSICIAN	**CURRENT TREATING PHYSICIAN CONTACT INFORMATION** *Please either type in the fields below or print out and hand write. Check mark on the left indicates the physician you want your records sent to;* ***a complete separate signed authorization is required.***
☐	Referring:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	
☐	Physician:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	
☐	Physician:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	
☐	Physician:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	
☐	Physician:	
	Specialty:	
	Address:	
	Phone:	
	Fax:	

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PATIENT RECORD OF DISCLOSURES

Please provide us with a telephone number at which you may be reached during the day in case we need to contact you regarding your daily appointment(s).

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone: ____________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Cell Telephone: ____________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone: ____________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Other: ____________________
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only

- ☐ Written Communication
  - ☐ OK to mail to my work/office address: ____________________ ____________________
  - ☐ OK to Email to this address: ____________________
  - ☐ OK to Fax information to this number: ____________________
- ☐ Ok to Email regarding Cancer Center services or classes. Email address: ____________________

Optional: I authorize Hoag Hospital to discuss my treatment and care with:

Name: ____________ Relationship: ____________ Telephone: ____________
Name: ____________ Relationship: ____________ Telephone: ____________
Name: ____________ Relationship: ____________ Telephone: ____________

Patient Signature: ____________________ Date: ____________ Time: ____________

Print Name: ____________________ Date of Birth: ____________________

*** Please notify us if any of your information changes***

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses on disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

OUT- PATIENT MEDICATION RECONCILIATION UPON ENTRY TO HOSPITAL

Date of Procedure/Visit: ____________________________ Primary Care Physician (PCP): ____________________

Date: ___________________________ Time: __________ PCP Phone #: _________________________________

Acknowledgement: I confirm that this is a complete and accurate list of my (patient's) current medications, to the best of my knowledge, including prescription and over the counter drugs. I understand that healthcare providers will make medical decisions based on this information.

Name of person completing this form: ____

ALLERGIES: List all allergies to medications, herbs, food, latex, IV contrast, and other. Describe the reaction.
☐ None (Example: Sulfa – rash)

____

____

____

CURRENT MEDICATIONS: List your prescriptions, herbal, and over-the-counter medicines you take.
☐ None ☐ Patient poor historian/No family present/Unable to obtain information at this time

Medication Name	Dose	Frequency	Reason	**Upon Discharge** Change in Regimen

Discharge – Additional Prescriptions and Specific Medication Instructions:
1.
2.
3.
4.
5.

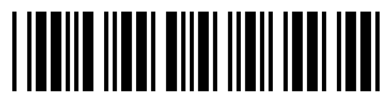
PATIENT INSTRUCTIONS: Above is the list of medications you indicated that you are currently taking. Resume taking your current medications, noting any checked boxes which indicate a change in your current medication regimen. Remember to follow the new medication instructions as directed. All medication changes or new prescriptions will be relayed to your referring physician. Please contact the physician who prescribed your medications if you have any questions. Your signature below means you understand these instructions.

______________________________ ____________ ____________ A.M./P.M.
[Patient/Parent/Conservator/Guardian] [Date] [Time]

______________________________ ____________ ____________ A.M./P.M.
[MD or Authorized Staff] [Date] [Time]

OUT-PATIENT MEDICATION RECONCILIATION
PS 1621 06/25/09 Side 1 of 2

Original – Patient Photocopy – Chart



[2517]

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Patient Name: ________________________ Date of Birth: ____________ Age: ______________

Stated Height: ______________ Stated Weight: ___________

Primary Language: ___________________ Interpreter Needed? ☐ Yes ☐ No For which language? __________

Telephone #'s: Home ( ) ______________ Work ( ) ______________ Cell ( ) ___________________

Contact Person: ____________________________ Contact Phone Number: ( ) ___________________

INTERNIST/PRIMARY CARE PHYSICIAN AND VISIT INFORMATION

Internist/PCP: ____________________ Last Visit: ________ Next Visit: ________ Prior to Surgery? ☐ Yes ☐ No

Cardiologist: _____________________ Last Visit: ________ Next Visit: ________ Prior to Surgery? ☐ Yes ☐ No

Other Specialist: __________________ Last Visit: ________ Next Visit: ________ Prior to Surgery? ☐ Yes ☐ No

ALLERGIES AND PREVIOUS SURGERIES

Allergies Title	Reaction

Previous Surgery Details	Surgery Year	Anesthesia Used

Please indicate if you have had any of the following CARDIAC/MEDICAL procedures listed below:

Angioplasty: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No Stent Placed? ☐ Yes ☐ No

Echocardiogram: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Stress Test: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

Pacemaker: ☐ Yes ☐ No Year Performed: _____ Done at Hoag? ☐ Yes ☐ No

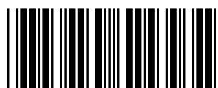
Pacemaker Brand: ________________ Pacemaker Model: ____________________________

Other Procedure: ____

CARDIOVASCULAR

- ☐ Angina/Chest Pain
- ☐ Congestive Heart Failure
- ☐ Heart Valve Problems
- ☐ Pain or shortness of breath when walking 2 blocks or climbing 1 flight of stairs
- ☐ Arrhythmias, i.e., A-Fib
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Cardiomyopathy
- ☐ Family History of Heart Disease
- ☐ History of DVT/PE
- ☐ Carotid Artery Disease
- ☐ Heart Attack
- ☐ Hypertension

Date of Heart Attack: ___________ Date of Chest Pain: _____________



Patient Name: ____

PULMONARY
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ CPAP
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Tuberculosis

HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding/Clotting Disorders
- ☐ Blood Transfusions
- ☐ Leukemia/Lymphoma

GASTROINTESTINAL
- ☐ Cirrhosis
- ☐ Digestive Problems
- ☐ Gastric Reflux
- ☐ Hepatitis A, B, or C

NEUROLOGIC
- ☐ Anxiety/Depression/Mood Disorders
- ☐ Dementia
- ☐ Fainting
- ☐ Headache
- ☐ Muscle Weakness
- ☐ Neuromuscular Disorders
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke/Mini Stroke

GENITOURINARY
- ☐ Dialysis
- ☐ Kidney Stones
- ☐ Prostate Disease
- ☐ Urinary Tract Infections

ENDOCRINE
- ☐ Diabetes
- ☐ Hypo/Hyperthyroidism
- ☐ Hypoglycemia
- ☐ Recent Steroid Therapy

PAIN
- ☐ Artificial Joints, Location: __________
- ☐ Back/Neck Pain
- ☐ Chronic Pain Treatment
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis

GENERAL HEALTHCARE

Do you, or have you ever had any of the following?

Cancer:

Have you had or have cancer? ☐ Yes ☐ No
Have you had radiation therapy? ☐ Yes ☐ No
Have you had chemotherapy? ☐ Yes ☐ No
Where was/is the cancer located? ________________

Have you had any of the following vaccines?

Ever taken the flu vaccine? ☐ Yes ☐ No
In what date: __________

Ever taken the pneumonia vaccine? ☐ Yes ☐ No
In what year: __________

For Female Patients:

Any possibility of pregnancy? ☐ Yes ☐ No
Date of last menstrual period? __________

Tell us about your social history:

Smoking History:

Do you smoke? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No
For how many years? __________
Any smoking in the past 12 months? ☐ Yes ☐ No

Alcohol History:

Do you drink alcohol? ☐ Yes ☐ No
How much alcohol do you consume and how often?

____

Drug History:

Do you use recreational drugs? ☐ Yes ☐ No
What kind of recreational drugs do you use?

____

Malignant Hyperthermia (MH) History:

Family history of MH? ☐ Yes ☐ No

SURGICAL INFORMATION

Do you exercise? ☐ Yes ☐ No If yes, Type: ____________________________
Do you wear contact lenses? ☐ Yes ☐ No
Do you have caps, bridges, dentures or loose teeth? ☐ Yes ☐ No

SIGNATURES

____

[Patient/Parent/Conservator/Guardian] [Date] [Time] [If completed by other than patient, indicate relationship]

____

[Reviewed by Assessment Nurse] [Date] [Time] [Reviewed by Procedure Nurse] [Date] [Time]

____

[Reviewed by PACU Nurse] [Date] [Time] [Reviewed by Discharge Nurse] [Date] [Time]

AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS
Hoag Memorial Hospital Presbyterian

Dear Patient:

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization:

Notice of Rights and Other Information:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to Hoag Hospital, Health Information Department, One Hoag Drive, Newport Beach, CA 92658. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Complete request information on reverse side...

Patient Name: ______________________________

Date of Birth: ______________ Social Security Number: _____ - ____ - __________

Use of disclosure: I hereby authorize Hoag Memorial Hospital Presbyterian to disclose the information listed below to: (List the person/organization authorized to receive this information.)

Name/Organization: ______________________________

Address: ______________________________

City: ______________ State: ______ Zip: ________ Phone: ______________

☐ Mail ☐ Patient will pick up ☐ Family member will pick up: Name: ________ Phone: ________

Requested Media: ☐ Paper ☐ CD

This authorization applies to the following:

☐ All health information pertaining to any medical history, mental or physical condition and treatment received, **OR**

☐ Only the following records or types of health information: Date of Service: __________

☐ ED Records	☐ History & Physical	☐ Consults	☐ Operative Report
☐ Discharge Summary	☐ MD Progress Notes	☐ MD Orders	☐ Nurse's Notes
☐ EKG, EMG, EEG	☐ Radiology Reports	☐ Anesthesia Records	☐ Lab/Pathology Reports
☐ Radiology Film/CD, Type: ______		☐ Other: ______	

I specifically authorize release of the following information (check as appropriate):

☐ Alcohol/drug treatment information ☐ HIV Test Results ☐ Mental Health Treatment Information

A separate authorization is required to authorize disclosure or use of psychotherapy notes.

Purpose for use/disclosure: ☐ Patient Request ☐ Further Medical Care ☐ Insurance **OR**
☐ Other: ______________________________

Expiration: This authorization expires (insert date or event): ______________________________

______________________ [Signature] __________ [Date] __________ [Time] A.M./P.M.

If signed by other than patient, indicate legal relationship to patient: ______________________

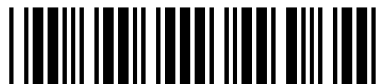
Witness: ______________________

AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORDS

JIT 2363 Side 2 of 2 Rev 08/10/11

Original – Chart Copy – Patient

MR #



[7715]

Request to Other Providers to Release Copies of Medical Records to HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Dear Patient:

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization:

Notice of Rights and Other Information:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the facility/provider listed on page 2. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance on this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

Complete request information on reverse side...

Patient Name: ____

Date of Birth: ____________________ Social Security Number: _______ - _____ - ____________

Use of disclosure: I hereby authorize:

Name/Organization: ____

Address: ____________________________ City: __________________ State: _____ Zip: __________

Phone: ____________________________ Fax: __________________

To release copies of my records to:

☐ **Hoag Memorial Hospital Presbyterian – Irvine**
16200 Sand Canyon Ave, Irvine, CA 92618
☐ Mail ☐ Fax #: ____________________ ☐ Attn: ________________________

☐ **Hoag Memorial Hospital Presbyterian – Newport Beach**
One Hoag Drive, PO Box 6100, Newport Beach, CA 92658-6100
☐ Mail ☐ Fax #: ____________________ ☐ Attn: ________________________

This authorization applies to the following:

☐ All health information pertaining to any medical history, mental or physical condition and treatment received, **OR**

☐ Only the following records or types of health information: Date of Service: __________________
Service type: ☐ Inpatient ☐ Outpatient ☐ Emergency

☐ ECU Records	☐ History & Physical	☐ Consults	☐ Operative Report
☐ Discharge Summary	☐ MD Progress Notes	☐ MD Orders	☐ Nurse's Notes
☐ EKG, EMG, EEG	☐ Radiology Reports	☐ Anesthesia Records	☐ Lab/Pathology Reports

☐ Other: ____

I specifically authorize release of the following information (check as appropriate):

☐ Alcohol/drug treatment information ☐ HIV Test Results ☐ Mental Health Treatment Information

A separate authorization is required to authorize disclosure or use of psychotherapy notes.

Purpose for use/disclosure: ☐ Patient Request ☐ Further Medical Care ☐ Insurance **OR**
☐ Other: ____

Expiration: This authorization expires (insert date or event): ______________________________

______________________________ ______________ __________ A.M./P.M.
[Signature] [Date] [Time]

If signed by other than patient, indicate legal relationship to patient: ______________________________

Witness: ______________________________________

REQUEST TO PROVIDE RECORDS TO HOAG
Side 2 of 2 NS80260 Rev 05/31/11

[7715]

Original – Chart Copy – Patient

MR #

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Irvine • Newport Beach

CONDITIONS OF ADMISSION - OUTPATIENT

The undersigned patient is admitted to Hoag Memorial Hospital Presbyterian ("Hospital") for inpatient, outpatient and / or emergency treatment subject to the following terms and conditions:

1. CONSENT TO MEDICAL AND SURGICAL PROCEDURE, TERM/DURATION OF CONSENT

The undersigned consents to the procedures that may be performed during this outpatient service treatment or services, or any other services, whether inpatient, outpatient, or emergency, performed at any Hospital facility while this consent remains in effect, which may include, but are not limited to, laboratory procedures, x-ray examinations, MRI, ultra sound or other out patient services. This consent will remain in full force and effect and be valid for the period of one year from date of the signing by the patient at Section 11 below, or until consent has been revoked in writing.

2. NURSING CARE

This hospital provides only general duty nursing care unless, upon orders of the patient's physician, the patient is provided more intensive nursing care. If the patient's condition is such as to need the service of a special duty nurse, it is agreed that such must be arranged by the patient or his / her legal representative. 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 the patient is not provided with such additional care.

3. PHYSICIANS ARE INDEPENDENT MEDICAL PRACTITIONERS

All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, emergency department physician, anesthesiologist, hospitalist, and the like, are independent medical practitioners and are **not** employees or agents of the hospital. They have merely been granted the privilege of using the Hospital for the care and treatment of their patients. Physician fees are billed separately from Hospital charges, and, therefore, patients may receive multiple bills. **Initial Here**: ________

The patient is under the care and supervision of his/her attending physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or Hospital services rendered to the patient under the general and special instructions of the physician.

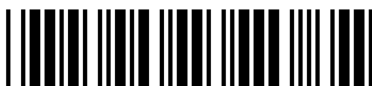
4. PERSONAL BELONGINGS

The patient is encouraged to leave personal items at home. The Hospital maintains a fireproof safe for the safekeeping of money and valuables. The Hospital is not liable for the loss or damage to any money, jewelry, documents, or other personal property items brought onto hospital property. The Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500) unless a written receipt for a greater amount has been obtained from the Hospital. **Initial Here:** ________

5. MATERNITY PATIENTS

If the patient delivers an infant(s) while a patient of this Hospital, the undersigned agrees to these same Conditions of Admission on behalf of the infant(s). **Initial Here:** ________

Patient Identification



[1213]

6. PARTICIPATION IN MEDICAL EDUCATION / TEACHING PROGRAMS

The undersigned acknowledges and understands that the Hospital participates in teaching programs and as such the training of physician fellows through a Medical Education Program, nurses and other health care personnel takes place at the Hospital and these individuals may participate in the operation, special diagnostic or therapeutic procedures, or treatment specified above under appropriate supervision and the undersigned hereby consents to such participation.

7. CONSENT TO PHOTOGRAPH

The undersigned consents to be photographed (includes video or still photography, in digital or any other format, and any other means of recording or reproducing images) while receiving treatment at the Hospital, with the understanding that the images from such photography may be used only for the patient's treatment or for Hospital health operations such as peer review or medical education, as the Hospital or the patient's treating physician(s) deem appropriate, but for no other purposes.

8. FINANCIAL AGREEMENT

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 promptly pay the account of the Hospital in accordance with the regular rates and terms of the Hospital, including its charity care and discount payment policies, if applicable. The undersigned understands that all physicians and surgeons, including the radiologist, pathologist, emergency department physician, anesthesiologist, hospitalist, and others, will bill separately for their services. Should any account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Initial Here: ________

9. ASSIGNMENT OF INSURANCE BENEFITS

The undersigned assigns and authorizes, whether he / she signs as agent or as patient, direct payment to the Hospital of any insurance benefits otherwise payable to or on behalf of the patient for this hospitalization or for these outpatient services. It is agreed that payment to the Hospital, pursuant to this authorization, by an insurance company shall discharge the insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he / she is financially responsible for charges not paid according to this assignment.

10. HEALTH PLAN (INSURANCE) OBLIGATION

This Hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from the Admitting and Registration Office. The Hospital has no contract, express or implied, with any plan that does not appear on the list. It is the patient's obligation to assure that the patient's health plan has authorized the services to be provided by the Hospital. The undersigned agrees that he / she is individually obligated to pay the account of the Hospital in accordance with the regular rate and terms of the Hospital, including its financial assistance policies, if he / she belongs to a plan which does not appear on the above-mentioned list or if the patient fails to obtain the health plan's authorization.

All physicians and surgeons, including the radiologist, pathologist, emergency department physician, anesthesiologist, hospitalist, and others, will bill separately for their services. It is the responsibility of the undersigned to determine if physicians providing services to the patient contract with the patient's health plan, if any. **Initial Here:** ________

Patient Identification

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Irvine • Newport Beach

11. ACKNOWLEDGEMENTS

a. This is to acknowledge that the undersigned has received the Patient Information which includes, Steps to Improve the Safety of Your health Care, *Rights and Responsibilities as a Patient,* and *Your Right to Make Decisions about Medical Treatment* (Advance Healthcare Directive information).

b. The undersigned acknowledges and understands that from time to time, the Hospital may provide services to its hospital patients through the use of outside resources or under arrangements with third parties, including, for example, services provided to Hospital patients by specialty reference laboratories or Hoag Orthopedic Institute. In these circumstances, the Hospital retains professional and administrative responsibility for all services provided to its Hospital patients by these outside resources.

Initial Here: _______

The undersigned certifies that he / she has read the Conditions of Admission, received a copy, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

[Signature of Patient/Parent/Conservator/Guardian]	[Date]	[Time] A.M./P.M.

[If signed by other than patient, indicate relationship]	[Hospital Representative]

FINANCIAL RESPONSIBILITY AGREEMENT BY PERSON OTHER THAN THE PATIENT OR THE PATIENT'S LEGAL REPRESENTATIVE

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits, and Health Plan Obligation provisions above.

[Signature of Financially Responsible Party]	[Date]	[Time] A.M./P.M.	[Hospital Representative]

Interpreter's Statement: I have accurately and completely read the foregoing document to the patient and / or, if appropriate, his / her legal representative in the ________________________ language, which the patient or legal representative had requested to be used.

[Signature of Interpreter]	[Date]	[Time] A.M./P.M.	[Print Name of Interpreter]

Patient Identification

HOAG MEMORIAL HOSPITAL PRESBYTERIAN

Irvine • Newport Beach

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that Hoag Memorial Hospital Presbyterian ("Hoag") including Hoag entities, may share my health information for treatment, billing and healthcare operations. I have been provided a copy of Hoag's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Hoag has the right to change this notice at any time. I may obtain an additional copy by contacting the hospital registration office or by visiting the website at www.hoag.org.

I acknowledge receipt of the Notice of Privacy Practices of Hoag Memorial Hospital Presbyterian.

Patient's Name: ____

Signature: ______________________________ Date: ______________
[Patient/Parent/Conservator/Guardian]

If signed by other than patient, indicate relationship: ________________________

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

☐ Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgement of Receipt.

☐ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices.

☐ Other: ____

Patient's Name: ____

Hoag Staff Signature: ____

Date: ____