SHERIDAN MEMORIAL HOSPITAL
1401 West 5th Street
Sheridan, WY 82801
(307) 672-1000

Name (last, first):
DOB: **Age:** **Sex:**
Attending:
FIN: **MRN:**

Conditions of Registration/Admission

PRIVACY NOTIFICATION: By signing below I acknowledge receipt of Sheridan Memorial Hospital's (SMH) **"Notice of Privacy Practices."** I understand that SMH may disclose my protected health information for the purposes of treatment, payment, and operations and that SMH's Privacy Notice is subject to change.

- Certain procedures at the hospital may be performed by outside providers who may bill patients for these services.
- SMH supports the education of a variety of supervised clinical students. These students may provide or observe patient care.
- A company representative(s) for specialized equipment or supplies may be present in Surgery or other specialized areas.
- Photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that SMH will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in SMH's policy. Images that identify me will be released or used outside the institution only upon written authorization from me or my legal representative.

I understand that information related to the public's health as defined by the Wyoming Department of Health and/or the Center for Disease Control and Prevention (CDC) is disclosed as required by law. I understand that SMH uses the ability to electronically send prescriptions and can request and use your prescription medication history from other health care providers and/or third party pharmacy benefit payers for treatment purposes; to include but not limited to formulary and benefit transactions, medication history transactions and fill status notification.

PATIENT RIGHTS & RESPONSIBILITIES: By signing below I acknowledge receipt of the SMH Patient Rights and Responsibilities notice.

MEDICAL CONSENT: I consent to routine medical treatment, emergency care or hospital services performed or prescribed at the direction of a physician in SMH. This consent includes radiology, laboratory, blood tests or other exams/procedures that are considered necessary or advisable by the physician, including tests for communicable diseases such as hepatitis and HIV/AIDS. At the discretion of the hospital, other consents may be required. I understand I have the right to refuse or opt out of part or all treatment, tests or procedures.

LIABILITY FOR LOSS OF PERSONAL PROPERTY: SMH provides a secure safe and is not responsible for valuables, health aides, or other personal property not placed in SMH's safe. SMH recommends anything of value over $10.00 be left at home, taken home, or placed in the safe.

ASSIGNMENT OF BENEFITS AND PROMISE OF PAYMENT: I assign SMH, and physicians or other health care providers who perform services for me during this visit, all benefits which are or shall become payable from any third party payer.

- I understand and agree that, even though I have assigned my benefits, I remain financially responsible for full payment of all medical care and treatment provided to me regardless of any nonpayment or reduced payment any of my third party payers determine to make on my behalf. Payment is due in full by me upon completion of services.
- If SMH submits any claim for services I have to a third party payer, it does so as an accommodation to me and does not thereby accept any terms, conditions, or limitations such third party payer may wish to apply.
- I agree to pay all collection expenses or attorney fees incurred in the collection of this account as a result of my failing to pay the same as agreed. I agree to pay an interest charge of 7% annual percentage rate on any unpaid balances. I understand that SMH reserves the right to assign my account with an unpaid balance for collection.

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SURVEYS: Our patients are selected at random for optional satisfaction surveys to evaluate our customer service.

CONTACT: I consent to be contacted, via the contact information I have provided, by SMH, its agents, its clinics, and any entity to which SMH assigns my account, by regular mail, by e-mail, by telephone (including wireless and mobile telephone numbers), or by text message, regarding any matter related to my healthcare and my account. I also consent to the use of any updated or additional contact information that I may provide as well as to the use of technology including auto-dialing and/or prerecorded messages in contacting me. I also agree to notify SMH and its clinics of any changes to my contact information.

The undersigned has read and understands the Conditions of Registration/Admission and accepts its terms. I verify that my e-signature represents my written signature.

_____

Patient's Signature Date Time

_____

Witness to Patient Signature Date Time

If the patient cannot sign upon admission due to condition the patient's representative must sign below.

_____

Signature Relationship to Patient Date Time

_____

Witness to Patient's Representative Signature Date Time