LIBERTY MEDICAL CENTER PO Box 705, Chester, MT 59522 406-759-5181 FAX 759-5071

IMPORTANT INFORMATION FOR LMC PATIENTS

GENERAL DUTY NURSING: Liberty Medical Center (hereinafter referred to as LMC) provides only general duty nursing care. Nurses are called to the bedside of the patient by a signal system. If the patient is in such condition as to need continuous or special duty nursing care, it is agreed that such must be arranged by or for the patient. LMC 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.

EMERGENCY SERVICES: LMC does not have a physician or mid-level provider on the hospital's premises 24 hours per day, 7 days per week. LMC has one provider on-call at all times to respond to emergency medical conditions. This provider will be available within 20 minutes. If transfer to another facility is necessary to provide you with appropriate medical care, LMC will provide medical treatment within our capacity to minimize risks to you and subsequently provide medically appropriate transportation to a facility that has the ability to meet your needs.

MEDICAL/SURGICAL CONSENT: The patient is under the control of his/her attending provider and LMC is not liable for any act or omission in following the instructions of providers. The undersigned consents to any x-ray examination, laboratory procedure, anesthesia, medical or surgical treatment or hospital services rendered under the general and specific instructions of the attending provider. The undersigned recognizes that doctors of medicine furnishing services, including the radiologist, pathologist and the like such as certified registered nurse anesthetists, are independent contractors and are not employees or agents of LMC.

RELEASE OF INFORMATION: LMC complies with all federal and state laws regarding the disclosure of confidential medical information. I have been offered a copy of Liberty Medical Center's Notice of Privacy Practices, which is also available on our website.

PERSONAL VALUABLES: It is understood and agreed that LMC maintains a locked area for safekeeping of money and valuables and LMC shall not be liable for the loss of, or damage to any money, jewelry, glasses, dentures, hearing aids, documents, or other articles of unusual value, unless placed therein.

ASSIGNMENT OF INSURANCE BENEFITS: In the event that the undersigned is entitled to hospital benefits of any type whatsoever arising out of any policy of insurance, Medicare, Medicaid, or any other party liable to the patient, said benefits are hereby assigned to LMC for application on the patient's bill. It is agreed that LMC may receipt for any such payment which shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient is responsible for charges not covered by this assignment. **The undersigned acknowledges it may be necessary to contact my insurance carrier in order to "pre-authorize" hospital treatment. It is my responsibility to know and follow the guidelines and requirements set forth in my insurance policy**.

FINANCIAL AGREEMENT: The undersigned agrees, whether signing as agent or as patient, that in consideration of the services to be rendered, to be individually obligated to pay the account of LMC in accordance with regular rates and terms of the credit policy of LMC. Should the account be referred to a collection agency, the undersigned shall pay reasonable collection fees/expenses. All delinquent accounts may bear interest at the legal rate. **I have received and have read a copy of the Financial Obligation Statement and understand that the full credit policy is available upon request.**

ADVANCE DIRECTIVES: (circle appropriate responses)
The undersigned **DOES DOES NOT** have a **LIVING WILL** and /or **DURABLE POWER OF ATTORNEY**.
On file at:

_____

My representative
is:_____

PATIENT RIGHTS: Patients at LMC have the right to

- access emergency healthcare services;
- our best efforts to assist you in being informed of your rights in your language or by an understandable method;
- participate in the planning and delivery of care;
- be informed of your personal health status and make informed decisions regarding care, including the right to refuse treatment;
- complete advance directives and have LMC staff comply with these directives in accordance with Federal rules and regulations;
- have a family member or representative notified of your admission; (name:_____ phone:_____ notified by:_____date/time:_____)
- have a medical provider notified of your admission to the hospital; (name:_____ phone:_____ notified by:_____date/time:_____)
- personal privacy;
- receive care in a safe environment;
- be free from abuse, neglect, or harassment from staff, other patients and visitors;
- the confidentiality of clinical records;
- access information contained in your clinical records within a reasonable time frame;
- be free of any physical or chemical restraints or seclusion unless required to treat medical symptoms;
- be represented by others if unable to participate in treatment decisions; (name:_____)
- considerate, respectful, and nondiscriminatory treatment at all times;
- a fair and prompt process for resolving concerns;
- and consent to receive or deny visitors, unless clinically contraindicated:
- file any concern with the Department of Public Health and Human Services, PO Box 202953, Helena, MT 59620-2953, 406-444-2099.

FOR MEDICARE PATIENTS ONLY: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. **I have received information concerning my level of care (inpatient or observation.) I also acknowledge that I have received a copy of the "Important Message from Medicare". My signature below only acknowledges my receipt of a copy of the "Important Message from Medicare" from LMC and does not waive any of my rights to request a review or make me liable for any payment.**

I have been provided with information concerning Advance Directives, Notice of Health Information Privacy Practices, LMC Financial Obligation Statement and Visitation Policy. These documents are also available on our website: http://www.libertymedicalcenter.org/

Patient refused these documents:_____ (staff initials)

The undersigned certifies that he/she has read the foregoing, has been offered a copy thereof, and is the patient or is duly authorized by the patient as general agent, to execute the above and accept its terms. This authorization may be revoked or amended at any time, by notifying the LMC Business Office Staff

_____	_____	_____
Patient/Patient's Representative	Relationship to Patient	Date
_____	_____	_____
Witness or Staff member	Date	Time