KANSAS CITY ORTHOPAEDIC INSTITUTE
CONSENT AND AGREEMENT FOR HEALTHCARE SERVICES

DISCLOSURE OF PHYSICIAN OWNERSHIP
According to Federal Regulations, the Kansas City Orthopaedic Institute meets the definition of a "physician-owned hospital" under 42 CFR 489.3. The hospital is owned, in part, by physicians who may be providing your care. A list of those physicians can be provided for review upon request.

You have the right to choose the provider of your health care services. Although we believe that the Kansas City Orthopaedic Institute will be able to meet your needs, you have the option to use a facility other than The Kansas City Orthopaedic Institute.

You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative health care providers.

CONSENT FOR TREATMENT
I consent to and authorize Kansas City Orthopaedic Institute to provide healthcare services under the general and specific instructions of members of the medical staff. I further consent to any examinations, tests, or procedures that may be deemed advisable or necessary in the diagnosis and treatment at the discretion of the professional staff. I am aware that the practice of medicine is not an exact science. I understand that no promise, guarantee, or warranty has been made regarding the result of medical treatment or examination. I authorize the entity or my physicians to take photographs or other images of me or parts of my body while under the care of the entity for use in identification, medical evaluation, education, or research. In the event that a healthcare worker, employee or volunteer is exposed to my blood or body fluids, my blood will be tested for hepatitis or Human Immunodeficiency Viral (HIV) infection. If my blood tests positive my physician will be notified.

RELEASE OF INFORMATION AUTHORIZATION
I authorize the Kansas City Orthopaedic Institute to release any or all of my medical or financial record to any person or corporation which is or may be liable under contract for all or part of the medical charges. I also authorize the entity to release information needed for treatment, payment and healthcare operation purposes to physicians, or entities that provide direct or indirect medical services to me while I am a patient at Kansas City Orthopaedic Institute.

PROVISION OF EMERGENCY SERVICES
The Kansas City Orthopaedic Institute's scope of care is limited to orthopaedics. Physicians are available on-call 24 hours per day, 7 days per week but may not be on the premises. There is a full complement of emergency equipment available and the nursing staff is trained in the use of that equipment and in basic and advanced cardiac life support should an emergency occur at KCOI. During your stay, should you need services not available at KCOI we have contractual agreements and affiliations with most surrounding hospitals to provide those services. Transportation to and from an affiliated facility will be arranged by KCOI based on the level of care required.

FINANCIAL AGREEMENT
I, the undersigned, whether acting as agent or patient, agree that in consideration for the services rendered or to be rendered do hereby assign payment directly to all hospital entities and any or all physicians of the benefits, otherwise payable to me, but not to exceed the hospital's regular charges for this hospitalization or outpatient service. I assign payment of physician benefits to the physician or organization furnishing the services, or authorize such physician or organization to submit a claim for payment. I hereby agree to pay any and all hospital charges that exceed or that are not covered by my hospitalization insurance coverage. THIS ASSIGNMENT IS IRREVOCABLE. I further understand that I am financially responsible for any penalties imposed by the insurance company or health plan and/or any charges not covered by this assignment of benefits.

RELEASE OF RESPONSIBILITY FOR VALUABLES AND PERSONAL PROPERTY
I understand that the Kansas City Orthopaedic Institute recommends that all personal belongings and valuables be sent home. I understand that the hospital is not responsible for loss or damage to any personal property I may choose to keep with me. I understand that personal electrical items may not meet the electrical safety requirements for a hospital and I may not be allowed to use any or all of my personal electrical devices during my stay at KCOI.

CONTRACTED SERVICES PROVIDED THROUGH KCOI
Some services or medical products prescribed by your Physician during your care at the Kansas City Orthopaedic Institute Hospital may be provided through contracted services and will be billed separately by another entity or authorized subcontractor to you or your insurance company directly. The services or products listed on the handout provided to you may not be covered by your insurance. If you object to the use of any product provided through a contractor, you are responsible for discussing that objection directly with your Physician prior to your procedure as your Physician is solely responsible for directing your care and treatment at KCOI. Any billing questions regarding the contractors on the patient handout should be directed through their individual offices as the staff at KCOI is not billing for the services or products that they have provided.

SMOKING POLICY
The Kansas City Orthopaedic Institute is a smoke free campus. I understand that smoking is prohibited anywhere in the facility or on the grounds of the facility.

PATIENT BILL OF RIGHTS AND PRIVACY NOTICE
These are important documents that describe your legal rights as a consumer of health care, how your medical information may be used and disclosed, and how to file a complaint if necessary. You have a right to make a written request for restrictions on how your medical information can be used. KCOI is not legally obligated to agree to any restriction requests.

I have been provided a copy and had the opportunity to review The Patient's Bill of Rights (_______) and

The Kansas City Orthopaedic Institute Privacy Notice. (_______) prior to affixing my signature below.

____
Signature of Patient, Authorized Agent, or Financially Responsible Party including relationship to patient

____
Printed Name of person signing if not patient

PATNAME	PHYS1NUM
PATBDAY	
PATAGE	
PATSEX	PATMRNUM

Consent for Treatment