



TERMS AND CONDITIONS OF SERVICE: ADMISSION, MEDICAL SERVICES AND FINANCIAL AGREEMENT

(Continued from other side)



Patient Label

6. FINANCIAL AGREEMENT: I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the services I receive, I agree to pay the Regents of the University of California for professional, hospital and ambulatory practice services, including University Physicians & Surgeons services, in accordance with the regular rates and terms of UC Irvine Health. I also agree to pay for other professional services provided at UC Irvine Health by other health care providers. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements and/or charity care. I also understand that when this agreement is signed by my spouse, parent or a financial guarantor, my spouse, parent or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate.

7. ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS): I authorize and direct payment to UC Irvine Health of any insurance benefits including hospital insurance and unemployment compensation disability benefits otherwise payable to me, or on my behalf, for UC Irvine Health services, including emergency services, at a rate not to exceed UC Irvine Health's actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance, or other sources, may be applied to any other account owed to UC Irvine Health by me.

I have read, agreed to and received a copy of this Terms and Conditions of Service.

_____ Signature of Patient	_____ Signature of Witness (required if patient is unable to sign)
_____ Signature of Patient's Representative	_____ Patient's Relationship to Representative
_____ Signature of Interpreter (if applicable)	_____ Language Used
	_____ Date of Signing
	_____ Time

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 (Paragraph 6) and Assignment of Benefits (including Medicare Benefits) (Paragraph 7) set forth above.

_____ Financially Responsible Party	_____ Witness	_____ Date of Signing	_____ Time
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(Reference other side for additional Terms and Conditions)



UC IRVINE HEALTH TERMS AND CONDITIONS OF SERVICE

1. UC IRVINE HEALTH: UC Irvine Health is part of the University of California and is comprised of its hospital(s), its medical center(s), its hospital-based clinics, its Ambulatory Practices, the University Physicians & Surgeons and the UC Irvine School of Medicine.

2. MEDICAL CONSENT: I consent to medical treatments or procedures, X-ray examinations, drawing blood for tests, medications, injections, taking of medical photographs, videotaping, laboratory procedures and hospital services rendered to me under the general and special instructions of the physicians or other health care professionals assisting in my care. I also consent to my admission to the UC Irvine Medical Center if this is necessary for my care.

3. TEACHING, RESEARCH AND HEALTH CARE INSTITUTION: The University of California including UC Irvine Health, is a teaching, research and health care institution. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, X-ray, rehabilitation therapy), post-graduate fellows and other trainees may observe, examine, treat and participate at the request and under the supervision of the attending physician in my care as part of the University's medical education programs. Some UC Irvine Health faculty are identified by their name badge as "Visiting Professors". These faculty members do not have a California license, but are licensed in another state or country. These physicians are permitted to practice medicine in California under a special program developed by the Medical Board of California.

I also understand that a University institutional review board approves projects conducted by University researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies, but I am under no obligation to do so. My decision whether to participate or not, will not affect my ability to obtain medical care.

4. USE OF MEDICAL INFORMATION AND SPECIMENS: I understand that my medical information, photographs and/or video in any form may be used for other UC Irvine Health purposes, such as quality improvement, patient safety and education. I also understand that my medical information and tissue, fluids, cells and other specimens (collectively, "Specimens") that UC Irvine Health may collect during the course of my treatment and care may be used and shared with researchers. I understand that under California law, I do not have any rights to any commercially useful products that may be developed from such research. I further understand that any use of my medical information or Specimens by UC Irvine Health or other research institutions will be in accordance with state and federal law, including all laws and regulations governing patient confidentiality, in the manner outlined in the UC Irvine Health's Notice of Privacy Practices.

5. RELEASE OF MEDICAL INFORMATION: The State of California Information Practices Act requires UC Irvine Health to provide the following information to individuals who supply information about themselves. As a patient of UC Irvine Health, I will be asked to submit certain personal identification information, such as a photo identification, my address, phone number, Social Security number, insurance information, medical history and treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care and payment for such care. Under the authority of The Federal Privacy Act of 1974, Article IX, Section 9 of the California Constitution, the California Information Practices Act (Civil Code 1798 et seq.), California Code of Regulations, Title 22, Section 70749, UC Irvine Health is authorized to maintain this information. As required by UC Irvine Health, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage.

UC Irvine Health will obtain my written authorization to release information about my medical treatment, except in those circumstances when UC Irvine Health is permitted or required by law to release information (see UC Irvine Health's Notice of Privacy Practices for a description of the specific circumstances under which UC Irvine Health may release this information). For example, UC Irvine Health may release a copy of my patient record to health care providers, health plans, governmental agencies and workers' compensation carriers. Additionally, I understand that if I am diagnosed with cancer, a reportable disease in California, UC Irvine Health is required by law to report my diagnosis to the California Department of Public Health.