Maternity Pre-Admission Form

Due date:_____
Last menstrual cycle:_____

PATIENT INFORMATION

Last name:_____ First name: _____ MI:_____
Maiden name:_____ Date of birth:_____ SSN:_____
Home phone:_____ Cell phone:_____ E-mail: _____
Mailing address:_____ City:_____ State:_____
Zip code:_____ Race:_____ Marital status:_____ Religion:_____
Employer:_____ ❑ Full-time ❑ Part-time
OB physician:_____ Primary care physician:_____
Pediatrician:_____

- Would you like to be an organ donor? ❑ Yes ❑ No
- Have you been seen at another Lovelace facility before? ❑ Yes ❑ No

EMERGENCY CONTACT (NOT LIVING WITH YOU)

Name:_____
Relationship:_____ Phone Number:_____-_____-_____

Spouse/Father of the Baby Information

Last name:_____ First name:_____
SSN:_____ Date of birth:_____/_____/_____ Phone Number:_____-_____-_____

INSURANCE INFORMATION

Would you like baby to be screened for Medicaid coverage? _____
Primary insurance company:_____ Name of policy holder:_____
Date of birth:_____ SSN:_____ Relationship:_____
Group name:_____ Group number:_____
Identification number:_____ Insurance company address:_____
City:_____ State:_____ Zip code:_____ Phone number:_____
Secondary insurance company: _____ Name of policy holder:_____
Date of birth:_____ SSN:_____ Relationship:_____
Group name:_____ Group number:_____
Identification number:_____ Insurance company address:_____
City:_____ State:_____ Zip code:_____ Phone number:_____

- What insurance will newborn be added to? ❑ Primary ❑ Secondary ❑ Other:_____
- Would you like to participate in the National's Children's Study? ❑ Yes ❑ No *(Valencia County Only)*

Hospital co-pays, deductibles and co-insurances are due at the time of service.

By signing below, I agree that the information provided to Lovelace is current and accurate.

Signature:_____ Date:_____

Lovelace Women's Hospital

Payment Expectations

Our first priority at Lovelace Women's Hospital is to provide excellent care to all of our patients. To maintain our ability to provide excellent care to every patient, the following payment expectations apply for NON-emergency services for both insured and uninsured patients seeking care at Lovelace Women's Hospital.

Lovelace will provide the necessary medical treatment regardless of a patient's in ability to pay in the event of an emergency.

Insured Patients

- Your deductible, co-payment and/or any co-insurance that may apply to your policy is due at the time of service.
    - A deductible is the contracted amount of money a patient must pay before their insurance plan pays the claim.
    - Co-insurance is the percentage you and your insurance plan will pay towards your medical expenses. Once you have paid your deductible, you will pay the remaining contracted percentage for your bill. For example, if your insurance plan is 70/30, your insurance plan would pay 70 percent and you would pay 30 percent of your medical bills after you have paid your deductible.
    - A co-payment is a fixed amount of money you pay each time you use your insurance. Co-payments are paid per visit and are typically smaller amounts.
- If you are scheduled for a NON-emergency medical procedure or service, we may contact you prior to your appointment to provide an estimated amount that will need to be paid for on your appointment date.
- Please note, commercial insurance does not cover 100 percent of medical procedures.

Uninsured Patients

- You will be asked for the full amount of all estimated charges at the time of service.
- Lovelace offers our self-pay patients a 70 percent discount for services. This amount is due at the time of service.
- We provide patients with a cost estimate so they are able make an informed decision before proceeding with requested service or procedure.

Birthing Packages

- We are pleased to offer two special birthing packages to our delivering moms. You must meet the following criteria to be eligible for the packages:
    - Do not have health insurance
    - Do not have coverage with your medical insurance applicable to maternity services
    - Patient must pay the package cost in full 30 days prior to delivery

Financial Assistance

- Our Financial Counselor is available to assist uninsured or underinsured patients who may have difficulty paying for services. This may include a payment plan and/or possible charity assistance for qualified patients and specific visit types. For more information call, 505.727.7829.

Accepted Payment Methods

- Cash, checks, debit and credit cards (Visa, MasterCard, and American Express)
- We do not accept Care Credit

Payment Arrangements

- If you are approved for a payment plan, you must comply with the agreed terms. If you fail to comply by missing a payment, your account will be considered delinquent and will be subject to additional collection terms.
    - This may include the inability to schedule appointments with our facility, as well as the referral of your account to an outside collection agency. These actions will most likely impact your credit.

Lovelace Women's Hospital

Birthing Packages

At Lovelace Women's Hospital, we are committed to making your visit as pleasant as possible. **We offer two birthing packages for patients who do not have health insurance or maternity benefits with their current insurance plan.**

Vaginal Delivery Plan

Requirements:

- Stay of 48 hours (or less) from the time of admission. This includes observation in triage. Both mom and baby are discharged at the same time.
- Uncomplicated vaginal delivery (a single birth with no intervention).
- This covers the nursery, but not the NICU.
- Full payment of $3,500 is required 30 days prior to **expected** delivery date.
- Epidurals are an additional $800 and are required to be paid in full at time of service.

C-Section Delivery Package

Requirements:

- Stay of 96 hours after delivery
- Covers a normal C-section delivery for mom and baby.
- Includes anesthesia.
- Full payment of $7,300 is required 30 days prior to **expected** delivery date.

These packages do not include fees charged by the physician or false labor charges. Those fees are billed separately and should be handled with the provider prior to delivery.

These packages do not include fees charged for services provided by external providers or labs.

Should complications arise, additional charges will be applied. Payment discounts are available and can be discussed with the financial counselor before discharge.

If the total amount is not paid for prior to the **expected** delivery date, the patient is no longer eligible for the package and may then be responsible for the full itemized bill.

Responsibility Statement:
The birthing package has been fully explained to me and I have a complete understanding. If the criteria above is not met and payment in full is not made with 30 days prior to delivery, the chosen packages will be voided and I will no longer be eligible for the reduced rate. I will still be responsible for payment in full before discharge.

Patient Signature Date

Patient Name (print)

To begin your payment process, contact the financial counselor at 505.727.7829.

Lovelace Women's Hospital

General Consent for Diagnosis and Treatment

- I consent to care, examination, procedures and treatment from Lovelace Health System (LHS) and its medical staff, employees, independent contractors and employees of placement agencies in connection with my outpatient and/or emergency treatment, and medications. If I am a pregnant patient, I consent to care, examination, procedures and treatment of my infant whether the care is provided in my room or in the NICU. I understand I have the right to refuse any care, treatment or services my physician of staff recommends to me or for my infant.
- I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of examinations, treatments or procedures performed by LHS and its providers.
- I understand that examination and treatment that I may receive in the LHS Emergency Department are provided on an emergent basis and are not intended to replace comprehensive and routine medical care.
- I accept all responsibility for my health and safety if for any reason I leave this LHS facility prior to being released by a health care provider.

Independent Status of Physicians, Residents, Medical Students and Nurses

CAUTION! Please Read Carefully Before Signing:

The medical treatment rendered during my hospital admission may be provided by physicians, residents, and medical students (under the supervision of physicians and/or residents). These physicians, residents, and medical students are independent contractors and not employees of the hospital. In addition, nursing care rendered during my hospital admission may be provided by nurses or other professional staff who are also independent contractors or employees of a placement agency and not employees of the hospital. By signing this document, I acknowledge that:

- I have received adequate notification of this relationship and that the hospital is released from liability and is not legally responsible for the acts or omissions of such individuals
- The hospital has not represented or taken any other action to induce me to believe that the physicians, residents, medical students and nurses are employees or agents of the hospital.
- I understand, I will receive a separate bill from the provider.

General Duty Nursing

- I understand that LHS provides only general duty nursing care. Private duty nursing may be arranged directly between an agency and the patient at the patient's expense.

☐ **Check to Acknowledge**

Release Medical Information, Assignment of Benefits, Insurance Claims and Payment of Charges

I understand that LHS will use my information for the purposes of treatment, payment and health care operations.

I authorize LHS to and any physicians involved in my care to disclose all or any part of my medical record, including mental health and/or substance abuse treatment records, and/or infectious disease records including but not limited to blood-borne diseases to any organization or insurance company that may be liable or responsible for payment of charges associated with my care and for all other purposes of benefit payment. If my injury is work related, I authorize the hospital to release any information from my medical records to my employer and/or its designee or any insurance company that provides insurance. For any medical devices I may receive, I agree to the release of my social security number and other required information to the manufacturer and the Food and Drug Administration. I understand that this information may be used to locate me should there be an issue related to the medical device(s).

I understand that information in my medical record is confidential but may be disclosed for purposes of medical education and research, professional review activities or review activities related to the cost, frequency, and quality of patient services provided. Otherwise, my medical record information will not be disclosed without my consent or the consent of my legal representative, unless required by law or a court order.

I understand that my medical records will be maintained in the Epic Electronic Health Records ("EHR") system. I understand and agree that my information may be accessed by another facility or provider who participates in our EHR system for purposes of my treatment, as well as for purposes of system operations and management, and evaluating and improving patient care.

I understand that state law requires the reporting of certain positive test results, such as hepatitis and the antibody for HIV/AIDS virus to the Health Department.

I understand that the costs of my medical treatment that are quoted to me prior to billing are estimates. Actual charges may be more or less, and additional charges such as consulting physician fees or costs of pharmacy, laboratory, and supplies may not be compiled prior to my discharge. All charges will appear on my monthly statement.

I authorize and irrevocably assign payment directly to LHS for the full amount of medical insurance benefits payable under the terms of my policy(s).

I understand that filing of an insurance claim does not discharge my responsibility for payment of the charges incurred.

I agree to pay the actual charges for my medical treatment, less the amount paid to LHS by third party payers, if any. LHS may obtain a credit report on me from a credit reporting agency. Should the account be referred for collection, I shall pay the reasonable cost of collection including attorney's fees.

I understand I am financially responsible for deductibles, coinsurance, and all services not covered by insurance benefits and/or entitlements. I understand that if LHS or any of its affiliates are out-of-network with my insurance plan, then my financial responsibility may include: (1) higher coinsurance and deductible amounts; and (2) LHS's full charges, including the amount that exceeds the allowable charges of an in-network preferred provider.

Medicare Patient's Certification

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 and/or the Medicare Program, its intermediaries or the Professional Standards Review Organization any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or group health plan, as my "authorized representative" (including as such term is used in 29 C.F.R. § 2560.503-1(b)(4), 2560.503-1(c)(1)): (1) the right and ability to act on my behalf in connection with any claim, right, cause in action, or appeal that I may have under such policy and/or plan, and (2) the right and ability to act on my behalf to pursue such claim, right, cause of action, or appeal, including any benefit claim or appeal of any adverse benefit determination, in connection with such policy of plan with respect to any medical or healthcare expenses (however described or denominated) incurred as a result of the services or supplies I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursements, and any other applicable remedies including, but not limited to, recovery of losses, equitable relief, penalties, fines, and any other relief provided for under the Employee Retirement Income Security Act (ERISA).

Personal Property Release

I understand that I am responsible for my own personal belongings that I bring to LHS and keep in my possession while I am in a patient care area I have been advised that the LHS Security Office provides a safe where my belongings and valuables can be placed for safekeeping until the time of my discharge.

☐ **Check to Acknowledge**

Weapons/Explosives/Drugs:

I understand that if at any time LHS believes there may be a weapon, explosive device, illegal substance or drug, or alcoholic beverage in my room or with my belongings, the hospital may search my room and belongings. These items may be confiscated and disposed of as determined to be appropriate to include delivery to law enforcement authorities.

TCPA Consent Disclosure

Consent to Email, Telephone Calls and Text Messages for Appointment Reminders, Healthcare Information, Discharge Instructions, Account and Billing Communications, and Other Communications.

By providing my telephone number (whether landline or wireless) and/or email address to Lovelace Health System, I expressly consent that Lovelace Health System and its employees and agents may contact me by telephone, short message services (SMS), or text at any telephone number (whether landline or wireless) I have provided to Lovelace Health System or, at any number forwarded or transferred from that number regarding any matter that is related to my treatment, my account, and/or Lovelace Health System's services, including, but not limited to the following:

my hospitalization or treatment, my condition and plan of care, the services rendered, patient surveys, discharge instructions, communication made to me or related to my account, or my related financial obligations including, but not limited to, payment reminders, delinquent notifications, instructions and links to patient billing information, and other healthcare communications including, but not limited to, notification and reminders of appointments, notification and reminders that certain medications are ready for pick-up, information about programs or services that might be of interest to me, information about insurance coverage/eligibility, information about referrals, and information about available treatment options and capabilities

These communications may be transmitted by or on behalf of Lovelace Health System and its employees and agents using pre-recorded/automated voice messages, use of an automatic dialing device, or other technologies. I understand that providing my prior express written consent to receive such communications is not a condition of receiving services or care from LHS. I understand that I will be able to change my preference at any time. This can be done via your MyChart account under Your Menu, then Accounting Settings, then Personal Information, or by contacting patient access/registration or your physician's office.

Electronic Prescribing

Our facility may participate in Electronic Prescribing and may be asking for your preferred pharmacy to submit any prescriptions necessary upon your discharge. To facilitate this process we will be submitting your phone number and address on file to your preferred pharmacy.

☐ I have received information about the *Incident Management System Program and Patient Rights and Responsibilities.*
☐ I have read this document, I have had my questions answered to my satisfaction, and understand and agree to the content of this document.

Signature: _____ Date: ____/____/____

☐ Patient ☐ Legal Representative_____

If patient is unable to sign, state reason:_____

☐ Interpreter used - Name:_____

Witness: _____ Date: ____/____/____ Time: _____

General Consent for Diagnosis and Treatment

- I consent to care, examination, procedures and treatment from Lovelace Health System (LHS) and its medical staff, employees, independent contractors and employees of placement agencies in connection with my outpatient and/or emergency treatment, and medications. If I am a pregnant patient, I consent to care, examination, procedures and treatment of my infant whether the care is provided in my room or in the NICU. I understand I have the right to refuse any care, treatment or services my physician of staff recommends to me or for my infant.
- I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of examinations, treatments or procedures performed by LHS and its providers.
- I understand that examination and treatment that I may receive in the LHS Emergency Department are provided on an emergent basis and are not intended to replace comprehensive and routine medical care.
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- I have received adequate notification of this relationship and that the hospital is released from liability and is not legally responsible for the acts or omissions of such individuals
- The hospital has not represented or taken any other action to induce me to believe that the physicians, residents, medical students and nurses are employees or agents of the hospital.
- I understand, I will receive a separate bill from the provider.

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- I understand that LHS provides only general duty nursing care. Private duty nursing may be arranged directly between an agency and the patient at the patient's expense.

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I understand that my medical records will be maintained in the Epic Electronic Health Records ("EHR") system. I understand and agree that my information may be accessed by another facility or provider who participates in our EHR system for purposes of my treatment, as well as for purposes of system operations and management, and evaluating and improving patient care.

I understand that state law requires the reporting of certain positive test results, such as hepatitis and the antibody for HIV/AIDS virus to the Health Department.

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I understand I am financially responsible for deductibles, coinsurance, and all services not covered by insurance benefits and/or entitlements. I understand that if LHS or any of its affiliates are out-of-network with my insurance plan, then my financial responsibility may include: (1) higher coinsurance and deductible amounts; and (2) LHS's full charges, including the amount that exceeds the allowable charges of an in-network preferred provider.

BABY

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I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or group health plan, as my "authorized representative" (including as such term is used in 29 C.F.R. § 2560.503-1(b)(4), 2560.503-1(c)(1)): (1) the right and ability to act on my behalf in connection with any claim, right, cause in action, or appeal that I may have under such policy and/or plan, and (2) the right and ability to act on my behalf to pursue such claim, right, cause of action, or appeal, including any benefit claim or appeal of any adverse benefit determination, in connection with such policy of plan with respect to any medical or healthcare expenses (however described or denominated) incurred as a result of the services or supplies I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursements, and any other applicable remedies including, but not limited to, recovery of losses, equitable relief, penalties, fines, and any other relief provided for under the Employee Retirement Income Security Act (ERISA).

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I understand that I am responsible for my own personal belongings that I bring to LHS and keep in my possession while I am in a patient care area I have been advised that the LHS Security Office provides a safe where my belongings and valuables can be placed for safekeeping until the time of my discharge.

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Weapons/Explosives/Drugs:

I understand that if at any time LHS believes there may be a weapon, explosive device, illegal substance or drug, or alcoholic beverage in my room or with my belongings, the hospital may search my room and belongings. These items may be confiscated and disposed of as determined to be appropriate to include delivery to law enforcement authorities.

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By providing my telephone number (whether landline or wireless) and/or email address to Lovelace Health System, I expressly consent that Lovelace Health System and its employees and agents may contact me by telephone, short message services (SMS), or text at any telephone number (whether landline or wireless) I have provided to Lovelace Health System or, at any number forwarded or transferred from that number regarding any matter that is related to my treatment, my account, and/or Lovelace Health System's services, including, but not limited to the following:

my hospitalization or treatment, my condition and plan of care, the services rendered, patient surveys, discharge instructions, communication made to me or related to my account, or my related financial obligations including, but not limited to, payment reminders, delinquent notifications, instructions and links to patient billing information, and other healthcare communications including, but not limited to, notification and reminders of appointments, notification and reminders that certain medications are ready for pick-up, information about programs or services that might be of interest to me, information about insurance coverage/eligibility, information about referrals, and information about available treatment options and capabilities

These communications may be transmitted by or on behalf of Lovelace Health System and its employees and agents using pre-recorded/automated voice messages, use of an automatic dialing device, or other technologies. I understand that providing my prior express written consent to receive such communications is not a condition of receiving services or care from LHS. I understand that I will be able to change my preference at any time. This can be done via your MyChart account under Your Menu, then Accounting Settings, then Personal Information, or by contacting patient access/registration or your physician's office.

Electronic Prescribing

Our facility may participate in Electronic Prescribing and may be asking for your preferred pharmacy to submit any prescriptions necessary upon your discharge. To facilitate this process we will be submitting your phone number and address on file to your preferred pharmacy.

☐ I have received information about the *Incident Management System Program and Patient Rights and Responsibilities.*
☐ I have read this document, I have had my questions answered to my satisfaction, and understand and agree to the content of this document.

Signature: _____ Date: ____/____/____

☐ Patient ☒ Legal Representative PT PARENT

If patient is unable to sign, state reason: PT IS A MINOR

☐ Interpreter used - Name: _____

Witness: _____ Date: ____/____/____ Time: _____

BABY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. Please refer to the Notice of Privacy Practices for complete description of uses and disclosures. I acknowledge that I have received a written Notice of Privacy Practices.

By signing below, I acknowledge that I have received a copy of the Lovelace Health System Notice of Privacy Practices and that I agree to uses and disclosures described in the Notice of Privacy Practices listed under the section: How We May Use and Disclose Your Health Information.

BABY	BABY	N/A
Patient Name (Print)	Signature	Date

-OR-

Patient Personal Representative (Print)	Signature	Date

LOVELACE HEALTH SYSTEM USE ONLY

Date acknowledgement received: _____

Signature of LHS employee: _____

-OR-

Reason acknowledgement was not obtained (declined to sign):

PATIENT IS A MINOR

BABY

Lovelace
Health System

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. Please refer to the Notice of Privacy Practices for complete description of uses and disclosures. I acknowledge that I have received a written Notice of Privacy Practices.

By signing below, I acknowledge that I have received a copy of the Lovelace Health System Notice of Privacy Practices and that I agree to uses and disclosures described in the Notice of Privacy Practices listed under the section: How We May Use and Disclose Your Health Information.

Patient Name (Print)	Signature	Date

-OR-

Patient Personal Representative (Print)	Signature	Date

LOVELACE HEALTH SYSTEM USE ONLY

Date acknowledgement received: _____

Signature of LHS employee: _____

-OR-

Reason acknowledgement was not obtained (declined to sign):

_____

_____

ADVLW

Lovelace Women's Hospital
4701 Montgomery Blvd., NE
Albuquerque, NM 87109

ADVANCED DIRECTIVE FOR HEALTHCARE
ADMT0003 (Rev 03/10/16)

Place *your initials* in the ( ) space to choose an Advance Directive.
***PART 1* - Advance Directive:** If I have a terminal condition that will result in my death within a short time or if I am in a coma that is irreversible to a reasonable degree of medical certainty:
( ) **I do** want my life prolonged as long as possible within the limits of generally accepted healthcare standards.
( ) **I do not** want my life prolonged AND
I ( ) do want or ( ) do NOT want artificial nutrition (tube feeding).
I ( ) do want or ( ) do NOT want hydration (intravenous fluids).
( ) **I choose** to make an anatomical gift of tissue or organs at the time of death.
( ) **I** want my **designated agent** to make these decisions for me.

***PART 2* - Power of Attorney for Healthcare:**

1. **Designation of agent:** I designate the following individual as my agent to make health-care decisions for me:
   Name:_____ Relationship:_____
   Telephone number with area code: (___)_____ 2nd phone #: (___)_____
   If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a healthcare decision for me, I designate as my **first alternate agent**:
   Name:_____ Relationship:_____
   Telephone number with area code: (___)_____ 2nd phone #: (___)_____
2. **Agent's authority:** My agent is authorized to obtain and review medical records, reports and information about me and the make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of healthcare to keep me alive, except as I state here:
   _____
3. **When Agent's Authority Becomes Effective:** My agent's authority become effective when my primary care practitioner and one other qualified health-care professional determine that I am unable to make my own health-care decisions. If I initial this box [ ], my agent's authority to make healthcare decisions form me takes effect immediately.
4. **Agent's Obligation:** My agent shall make healthcare decisions for me in accordance with this power of attorney for healthcare, any instructions I give in PART 1 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make healthcare decisions for me in accordance with what my agent determines to be in my best interest, my agent shall consider my personal values to the extent known to my best agent.

- Regardless of the choices I have made above, I direct that the best medical care possible be given to keep me clean, comfortable and free of pain or discomfort at all times so that my dignity is maintained, even if this care hastens my death.
- If at any time you wish to revoke or make changes to this Advance Directive, another form will be completed to state your wishes.
- For any medical questions about your Advance Directives, you must consult your physician.
- You do not need a lawyer but should consult one for specific legal questions.

OTHER WISHES: If you wish to write your own instructions, or you wish to add to the instructions you have given above, you may do so here:

_____

Date:___/___/____ Time:_____ Patient Signature:_____

Lovelace Women's Hospital
4701 Montgomery Blvd., NE
Albuquerque, NM 87109

WAIVER OF INTERPRETER'S SERVICES

ADMT0113 (Rev 10/03/17)

I, _____ (Patient's name) have been told of my right under federal law to have free qualified interpretation services from [facility name] to explain to me via telephone interpretation or in person, in my native language, information concerning my medical treatment. I understand that I am entitled to these services at no cost to me or my family.

- ☐ I am declining interpreter services at this time.
- ☐ I am choosing to provide my own interpreter at this time. The name of my interpreter is _____. To the best of my knowledge, this person is 18 years old or over. This person will provide services to me beginning on _____ (start date) through _____ (end date). I acknowledge that the staff of [facility name] discussed with me the risks of using friends or family members as my medical interpreters.

These risks, as explained to me by [facility name], include but are not limited to the following:

- Family members or friends may not have bilingual skills and technical vocabulary required to interpret information completely and accurately concerning my medical treatment
- Family members and friends may not feel bound to uphold the same standards of privacy, confidentiality, ethics, and linguistic accountability as professional, qualified, medical interpreters
- Issues may arise concerning my medical treatment that may be sensitive and/or difficult to discuss with me through a family member or friend.

I understand that by using friends or family members as my interpreters, confidential information will be disclosed to the friends and family members and I agree that this disclosure can be made.

I understand that by using a friend or family member as my interpreter, my assessment and/or medical treatment may be delayed if he/she is not present when needed.

I understand that I can end ("revoke") this waiver at any time and be able to use the services of an interpreter provided by [facility name] at no cost.

I also understand that this waiver does not give permission for any interpreter to act as my authorized representative.

This form was translated for me and I understand it.

Patient/Surrogate/Responsible Party

Signature _____ Date / Time _____

Relationship to Patient _____

Interpreter's Signature _____ Date / Time _____

Staff Member's Signature _____ Date / Time _____

Patient Refuses to Sign ☐

Witness Signature _____ Date _____

This section for future use

I choose to end (revoke) this waiver.

Signature_____ Date_____

Explanation of Document (for providers and staff)

[Name of facility] policy requires that trained interpreters interpret for Limited English Proficient and Deaf/Hard-of-Hearing clients in order to ensure patient safety and accurate communication between the client and his/her service team. Patients have the right to refuse the interpreter and to have a family member or friend interpret, but the potential risks of using an untrained interpreter must first be explained to them in their language. They must also sign this form each time they waive interpreter services, and it must be placed in their permanent record. The trained interpreter will remain in the room in order to intervene in the event that the family member/friend is unable or unwilling to interpret correctly.

Payment Expectations

Our first priority at Lovelace Women's Hospital is to provide excellent care to all of our patients. To maintain our ability to provide excellent care to every patient, the following payment expectations apply for NON-emergency services for both insured and uninsured patients seeking care at Lovelace Women's Hospital.

Lovelace will provide the necessary medical treatment regardless of a patient's in ability to pay in the event of an emergency.

Insured Patients

- Your deductible, co-payment and/or any co-insurance that may apply to your policy is due at the time of service.
    - A deductible is the contracted amount of money a patient must pay before their insurance plan pays the claim.
    - Co-insurance is the percentage you and your insurance plan will pay towards your medical expenses. Once you have paid your deductible, you will pay the remaining contracted percentage for your bill. For example, if your insurance plan is 70/30, your insurance plan would pay 70 percent and you would pay 30 percent of your medical bills after you have paid your deductible.
    - A co-payment is a fixed amount of money you pay each time you use your insurance. Co-payments are paid per visit and are typically smaller amounts.
- If you are scheduled for a NON-emergency medical procedure or service, we may contact you prior to your appointment to provide an estimated amount that will need to be paid for on your appointment date.
- Please note, commercial insurance does not cover 100 percent of medical procedures.

Uninsured Patients

- You will be asked for the full amount of all estimated charges at the time of service.
- Lovelace offers our self-pay patients a 70 percent discount for services. This amount is due at the time of service.
- We provide patients with a cost estimate so they are able make an informed decision before proceeding with requested service or procedure.

Birthing Packages

- We are pleased to offer two special birthing packages to our delivering moms. You must meet the following criteria to be eligible for the packages:
    - Do not have health insurance
    - Do not have coverage with your medical insurance applicable to maternity services
    - Patient must pay the package cost in full 30 days prior to delivery

Financial Assistance

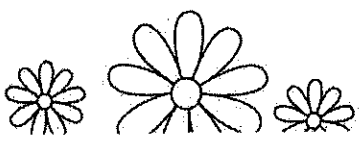
- Our Financial Counselor is available to assist uninsured or underinsured patients who may have difficulty paying for services. This may include a payment plan and/or possible charity assistance for qualified patients and specific visit types. For more information call, 505.727.7829.

Accepted Payment Methods

- Cash, checks, debit and credit cards (Visa, MasterCard, and American Express)
- We do not accept Care Credit

Payment Arrangements

- If you are approved for a payment plan, you must comply with the agreed terms. If you fail to comply by missing a payment, your account will be considered delinquent and will be subject to additional collection terms.
    - This may include the inability to schedule appointments with our facility, as well as the referral of your account to an outside collection agency. These actions will most likely impact your credit.



Lovelace
Women's Hospital

Effective as of February 20, 2019

LOVELACE HEALTH SYSTEM
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protected health information is stored electronically and is subject to electronic disclosure.

If you have any questions about this notice, please contact the Lovelace Health System (LHS) Privacy Officer at (505)727-7350.

This Notice Describes Our Practices And Those Of:

- Any medical staff member and any health care professional who participates in your care;
- Any volunteer we allow to help you while you are here; and
- All employees of any hospital, clinic, laboratory, or other facility affiliated with LHS.

All of these people follow the terms of this notice. They may also share health information that identifies you (also known as "protected health information") with each other for treatment, payment or health care operations as described in this notice.

Our Pledge Regarding Health Information:

We understand that health information about you and your health is personal. We are committed to protecting health information about you. This notice will tell you about the ways that we may use and disclose health information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of protected health information. We are required to comply with any state laws that offer a patient/plan member additional privacy protections.

We Are Required By Law To:

- Maintain the privacy of health information that identifies you;
- Give you and other individuals this notice of our legal duties and privacy practices with respect to protected health information;
- Follow the terms of the notice that is currently in effect; and
- Notify affected individuals in the event of a breach involving unsecured protected health information.

How We May Use And Disclose Your Health Information:

- **For Treatment**. We may use and disclose your health information to provide you with medical treatment or services. For example, a health care provider, such as a physician, nurse, or other person providing health services will access your health information to understand your medical condition and history. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. This information is necessary for health care providers to determine what treatment you should receive and to coordinate your care.

- **For Payment**. We may use and disclose your health information for purposes of receiving payment for treatment and services that you receive. For example, we may disclose your information to health plans or other payors to determine whether you are enrolled with the payor or eligible for health benefits or to submit claims for payment. The information on our bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may provide health information to entities that help us submit bills and collect amounts owed, such as a collection agency.

- **For Health Care Operations**. We may use and disclose your health information for operational purposes. For example, your health information may be used by, and disclosed to, members of the medical staff, risk or quality improvement personnel, and others to evaluate the performance of our staff, to assess the quality of care and outcomes in your case and similar cases, to learn how to improve our facilities and services, for training, to arrange for legal or risk management services and to determine how to continually improve the quality and effectiveness of the health care we provide.

- **Health Information Exchange**. We may participate in one or more health information exchanges or other health information registries and may use and disclose your health information through these exchanges for certain purposes described in this notice. For example, we may disclose your health information to or obtain your health information from other participants in a health information exchange that have treated you in order to coordinate your care. We may use a health information exchange to obtain information for payment for the care you receive. We may also disclose or obtain your health information through a health information exchange for quality assessment or improving health and reducing health care costs. We may disclose your health information to an electronic health information registry to report certain diseases or for other public health purposes.

- **Facility Directory**. Unless you object, we may include you in the facility directory. This information may include your name, location in the facility, general condition (*e.g.*, fair, stable, *etc.*) and religious affiliation. We may give your directory information, except for religious affiliation, to people who ask for you by name. Unless you object, your religious affiliation and other directory information may be released to members of the clergy even if they do not ask for you by name.

- **Others Involved In Your Care**. We may disclose relevant health information to a family member, friend, or anyone else you designate in order for that person to be involved in your

care or payment related to your care. We may also disclose health information to those assisting in disaster relief efforts so that others can be notified about your condition, status and location.

- **Fundraising**. We do not use or disclose your information for fundraising.

- **Required By Law**. We may use and disclose information about you as required by law. For example, we are required to disclose information about you to the U.S. Department of Health and Human Services if it requests such information to determine that we are complying with federal privacy law.

- **Reporting Abuse, Neglect or Domestic Violence**. We may disclose health information to an appropriate government authority, including a protective services agency, if we believe an individual is the victim of abuse, neglect or domestic violence. We will inform the individual that we have made such a report, unless we believe that doing so would place the individual at serious risk of harm. We will make such reports only as required or authorized by law, or if the individual agrees.

- **Public Health**. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities (*e.g.*, state health department, Center for Disease Control, *etc.*) to prevent or control disease, injury, or disability, or for other public health activities.

- **Law Enforcement Purposes.** Subject to certain restrictions, we may disclose information needed or requested by law enforcement officials.

- **Judicial And Administrative Proceedings.** We may disclose information in response to an appropriate subpoena, discovery request or court order.

- **Health Oversight Activities**. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections to monitor the health care system.

- **Decedents**. Health information may be disclosed to funeral directors, medical examiners or coroners to enable them to carry out their lawful duties.

- **Organ/Tissue Donation**. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

- **Research**. We may use or disclose your health information for research purposes after a receipt of authorization from you or when an institutional review board (IRB) or privacy board has waived the authorization requirement by its review of the research proposal and has established protocols to ensure the privacy of your health information. We may also review your health information to assist in the preparation of a research study.

- **Health And Safety**. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

- **Government Functions**. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

- **Workers' Compensation**. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

- **Business Associates**. We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

- **Other Uses And Disclosures**. We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. Except for uses and disclosures described above, we will only use and disclose your health information with your written authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization. You may revoke an authorization by notifying us in writing, except to the extent we have taken action in reliance on the authorization.

Your Health Information Rights:

You have the right to:

- Obtain a paper copy of this notice of information practices upon request, even if you have previously agreed to receive this notice electronically.

- Inspect and obtain a copy of your health information that we maintain, or direct us to send a copy of your health information to another person designated by you in writing. In most cases we will provide this access to you, or the person you designate, within 30 days of your request.

- Request an amendment to your health information if you think it is incorrect or incomplete. We may say "no" to your request, but we will tell you why within 60 days of receiving your request.

- Request a confidential communication of your health information by alternative means or at alternative locations. Please be advised that this request for alternative means or locations of communications applies only to this provider or location.

- Receive an accounting (a list) of the disclosures we have made of your health information for the six years prior to your request, except for certain disclosures that we are not required to include (such as disclosures that you have authorized us to make). We will also include in the list the reason for the disclosure and the recipient. We will provide one accounting per year at no charge, but if you ask for additional accountings within the same 12-month period, we may charge a reasonable, cost-based fee.

- Request a restriction on certain uses and disclosures of your information. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid for the item or service covered by the request out-of-pocket and in full and when the uses or disclosures are not required by law.

If you have given another individual a medical power of attorney, or if another individual is appointed as your legal guardian or is authorized by law to act on your behalf, that individual may exercise any of the rights listed above for you. We will confirm this individual has the authority to act on your behalf before we take any action.

To exercise any of these rights, please contact our Privacy Officer at the address at the end of this notice.

Changes To This Notice:

We reserve the right to change the terms of this notice and make the new terms effective for all protected health information kept by LHS. We will post a copy of the current notice in our facility and on our website, http://www.lovelace.com. You may also get a current copy by contacting our Privacy Officer at the address at end of this notice. The effective date of the notice is in the top right-hand corner of each page.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with LHS or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with LHS, submit your written complaint to our Privacy Officer at the address at end of this notice. You will not be penalized for filing a complaint.

Contact Information For Questions Or To File A Complaint:

If you have any questions about this notice, want to exercise one of your rights that are described in this notice, or want to file a complaint, please contact the LHS Privacy Officer at:

Lovelace Medical Center
601 Dr. Martin Luther King Jr. Ave. NE
Albuquerque, New Mexico 87102
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Regional Hospital - Roswell
117 East 19th Street
Roswell, New Mexico 88201
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Heart Hospital of New Mexico
504 Elm St. NE
Albuquerque, New Mexico 87102
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace UNM Rehabilitation Hospital
505 Elm St. NE
Albuquerque, New Mexico 87102
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Westside Hospital
10501 Golf Course Rd. NW
Albuquerque, New Mexico 87114
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Women's Hospital
4701 Montgomery Blvd. NE
Albuquerque, New Mexico 87109
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Central Billing Office
4411 The 25 Way NE, Suite 100
Albuquerque, New Mexico 87102
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

Lovelace Medical Group/New Mexico Heart Institute
4101 Indian School Rd. NE
Albuquerque, New Mexico 87110
Phone: (505) 727-7350
E-mail: LovelacePrivacy@Lovelace.com

You have the right to get the health care you need without concern for age, race, color, beliefs, nationality, gender, or sexual preference. Information regarding your rights as a patient must be provided to you or your designated representative in advance of giving or stopping care.

AS A PATIENT YOU HAVE THE RIGHT TO:

- A Medical Screening exam and stabilization even if you cannot pay for it.
- Have the services of a language interpreter arranged for you at no charge to you. The interpreter can help you talk and understand doctors and other staff. The interpreter can help you talk to and understand doctors and other staff. The interpreter can help you communicate your needs to hospital staff.
- Ask that a family member or friend and a physician or healthcare provider of your choice be notified if you are kept overnight in the hospital.
- Have family or a chosen representative participate in discussions of treatment options.
- Be treated with courtesy and respect in a way that respects privacy, confidentiality, security and dignity.
- An environment that preserves dignity and contributes to positive self image.
- Get care in a safe setting that is free of mental, physical, sexual and verbal abuse, neglect and exploitation.
- Know who is on the team providing your healthcare.
- Be involved in making decisions about your treatment and care.
- Be informed of any unexpected adverse event.
- Refuse or accept care, treatment, procedures, or services in accordance with the law and regulations.
- Be asked about your pain and to have your pain managed appropriately.
- Be free from being tied down, given sedation medicine or put into a room alone to control behavior problems except in emergencies. These methods are allowed only to keep someone safe if all other available methods have failed.
- The hospital respects the rights to and need for effective communication. The hospital does not participate in programs where patients have an opportunity to work.
- Be free to communicate without restriction (mail, telephone, visitors or other forms of communication) unless the restrictions are with your participation and evaluated for therapeutic effectiveness.
- Information about what is thought to be wrong with you, what treatment you can expect, the purpose of any procedure that the provider suggests as well as the anticipated outcomes of care, treatment, and services.
- Receive teaching about self-care after discharge.
- Receive adequate information related to research, investigation and clinical trials for which you may be eligible.
- Receive a full explanation of your bill, insurance coverage, services, and treatments that are provided.
- The following in regards to your medical records and health information
  - See or obtain a copy of your medical records in a reasonable amount of time
  - Request to write an amendment to your health information under certain circumstances
  - Obtain a copy of the Lovelace Health System Joint Notice of Privacy Practices upon request
  - The right to confidentiality and to information about how and/or when Lovelace Health System may use or share your health information
  - Obtain an accounting of where Lovelace Health System has shared your protected health information in the past 6 years, beginning April 14, 2003
  - Request that your health information be communicated with other institutions or health care providers in a confidential manner
  - Restrict certain uses and disclosures of your health information (with Privacy Officer approval)
- Have access to protective or advocacy services, through Child Protective Services or Adult Protective Services
- Express your concerns/complaints without fear of reprisal, and have them responded to in a timely manner
- Appeal your discharge if you feel it's premature

PATIENT IDENTIFICATION

- Have a family member, friend or other individual present of your choice with you for your support for during the course of your stay. You have the right to receive the visitors you want. Visitors could be a spouse, a domestic partner, a same-sex domestic partner, a family member, a friend, or anyone else you want. You may change your mind at any time. The hospital may limit visitation if problems occur or for safety, security or patient care reasons.
- Accommodation for individuals with disabilities and the services provided to help patients with communication needs or mobility issues.
- Be free from discrimination.
- Designate a surrogate decision-maker of your choice.
- To receive information in a manner that you and your surrogate decision-maker understands.
- If you are unable to make decisions due to your medical condition, your surrogate decision-maker has these rights.
- To receive written information about advanced directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative measures.

Just as a patient has certain rights, they and their families also have the following responsibilities:

YOU ARE RESPONSIBLE FOR PARTICIPATING IN THE SAFE DELIVERY OF CARE BY:

- Giving correct and complete health-related information
- Knowing what medicines you take
- Telling your health care provider of any changes in your health
- Asking questions to help you understand what has been explained and what you are supposed to do
- Following the treatment plan or telling your health care provider that you cannot follow it
- Accepting the results of refusing treatment or not following the treatment plan
- Reading and understanding the information you are given about health care benefits
- Canceling appointments that you cannot keep
- Following hospital rules about patient care and safety
- Meeting your financial obligation agreed upon with the hospital
- Treating other patients and hospital staff with respect
- Respecting the property of other people and of the healthcare organization
- Giving your opinions, concerns or complaints in a helpful way to the right people
- Respect the hospital's smoke free environment, which includes any tobacco, tobacco products and electronic cigarettes

ADVANCE HEALTHCARE DIRECTIVES

• An advance directive lets healthcare workers know what kind of care you want if you are unable to communicate with us, such as being in a coma. The document can be used by you to name someone to make decisions for you. Sometimes advance directives are called Living Wills or Durable Power of Attorney for Health Care Decisions.

• You have the right to make, review or revise an advance directive. If you need help, please ask. We have staff who can help you make, review or revise an advance directive. We will honor your advance directive or organ donation wishes in accordance with law, regulation, our capability and hospital policy.

PATIENT IDENTIFICATION

Complaints or grievances concerning alleged violations of patient rights or alleged hospital Advance Directive non-compliance are to be addressed by contacting (505) 727-7008 and requesting to speak with the Patient Relations Representative.

All grievances about situations that endanger the patient, such as neglect or abuse, should be reviewed immediately, given the seriousness of the allegations and the potential for harm to the patient. Contact the House Supervisor at **(505) 727-7882 or (505) 205.4786**.

The New Mexico Department of Health Incident Management Services and the New Mexico Medical Review Association are dedicated to providing assistance through information, counseling, education, advocacy and resolving disputes between patients and hospitals. Their contact information is listed below.

If you are a Medicare recipient and have any complaints or concerns or feel that your discharge is premature, you may ask for a review by the KEPRO, for quality of care concerns, coverage decisions, or if you wish to appeal your discharge.

IF YOU HAVE ANY COMPLAINTS OR CONCERNS OR FEEL THAT YOUR DISCHARGE IS PREMATURE YOU MAY:

Ask for review by the New Mexico Medical Review Association, for quality of care concerns, coverage decisions, or if you wish to appeal your discharge.

And report your concern to:

The New Mexico Department of Health Incident Management Services
1190 St. Francis Drive, Santa Fe, NM 87505
Phone: 1.800.752.8649 Fax: 1.888.576.0012
Email to: incident.management@state.nm.us
Website: dhi.health.state.nm.us/imb/index.php

KEPRO
5201 West Kennedy Blvd, Suite 900
Tampa, FL 33609
Phone: 1.888.315.0636 Fax: 1-844-878-7921 TTY: 1-855-843-4776
Website: www.keproqio.com

DNV-GL Healthcare Hospital Complaint
400 Techne Center Dr., Suite 100
Milford, OH 45150
Phone: 1.866.496.9647 Fax: 1.513.947.1250
Email: hospitalcomplaint@dnvgl.com

PATIENT IDENTIFICATION

The Department of Health's Incident Management System's goal is to prevent the occurrence of abuse, neglect, and exploitation of individuals who receive care in licensed health care facilities.

Lovelace Health System participates in this program by identifying and reporting abuse, neglect, or misappropriation of consumers' property.

DEFINITIONS

- **Abuse:** The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.
- **Neglect:** The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness
- **Consumer:** Any person who engages the professional services or a health care professional as an inpatient or outpatient.
- **Misappropriation of property:** the deliberate misplacement of consumer's property or wrongful, temporary, or permanent use of belongings or money without the consumer's consent.

Facility Process for Reporting Abuse and Neglect

- First, the safety of the consumer will be ensured. This includes:
  - Separating the consumer from the alleged perpetrator
  - Providing needed first aid and medical care
  - Determining if the incident is reportable
- Reporting is mandatory for suspected abuse of dependent or elderly adults and children under 18 years of age.
- Reporting shall occur within 24 hours (or next business day if the incident occurs on a weekend or holiday) to the Department of Health Division of Health Improvement.
- The person with direct knowledge of the incident should complete the first page of the Incident Report Form which can be found online.

Who can report abuse and neglect?

Any consumer, employee, family member, or legal guardian can report incidents of abuse and neglect either on their own or through a licensed health care facility. If an incident is reported to a Lovelace staff member, the Department of Health must be notified through the above process.

ALL REPORTING IS CONFIDENTIAL

- **For allegations of abuse, neglect or exploitation—Call 1-800-445-6242 - Hotline 24/7**
- **Adult Protective Services - 1-866-654-3219**
  http://dhi.health.state.nm.us/imb/index.php.

What does Lovelace do with this information?

- Lovelace has an active quality program which reviews complaints and incidents and a process for documenting corrective and preventative actions.
- All events reported to the Department of Health Incident Management System are reviewed as a part of this quality program.

Making Medical Choices

Questions & Answers About Your Right to Decide

Questions patients often ask about their healthcare.

- Who will make medical choices for me if I am unable to do so?
- May I accept or refuse medical treatment on the basis of my values, preferences and beliefs?
- Will my wishes for medical care at the end of my life be honored?

The Lovelace Health System believes that your medical care should reflect your wishes as much as possible. We offer this information to help you begin thinking about such medical choices. We also encourage you to discuss these choices with your family, friends, clergy and physician. You may want to write down your wishes as you think and talk about them.

Your right to direct your future healthcare.

As a competent adult, you have the right to make decisions about your healthcare. This includes the right to accept or refuse medical or surgical treatment, and the right to plan and direct the types of healthcare you may receive in the future if you become unable to express your wishes. You can do this by making Advance Directives.

- Competent adults are presumed able to make their own healthcare decisions unless assessment by two licensed healthcare professionals determines otherwise.

When you are admitted to a Lovelace Health System hospital, we will ask if you have prepared an Advance Directives form or if you would like information about this document.

What is a Durable Power of Attorney For Healthcare?

Durable Power of Attorney is a term you will see on the Advance Directives form. It is the "power" you give another person, usually your closest relative or friend, to be your "health-care agent". This person will make healthcare decisions for you if you are unable to do so. This means you are giving him or her the authority to make a wide range of healthcare decisions for you. On your Advance Directives form, you may list treatments you want or do not want, such as surgery or artificial life support.
Because your healthcare agent will make decisions for you based on what he or she knows about you and thinks you would want, it is important to discuss your treatment preferences with him or her. Please remember, someone else will speak for you only when you cannot do so for yourself.

What if I change my mind?

You may cancel or replace your Advance Directives at any time. An explanation of how to do this is on the Advance Directives document. To cancel or change a verbal directive, talk to your physician.

Lovelace Health System supports patient rights to make healthcare decisions.

At Lovelace Health System, we want you to participate as fully as possible in your medical care. This brochure has been prepared in compliance with the Patient Self Determination Act of 1990 and related New Mexico laws.

What are Advance Directives for healthcare?

Advance Directives tell who you want to make healthcare decisions for you if you cannot express them yourself, and your choices about what treatments you want or do not want. Advance Directives allow you to express your wishes based on personal wishes and beliefs.

There are two ways to make Advance Directives:

1) **In Writing:** You may designate, in writing, a person to make healthcare decisions for you and make choices about your medical treatment. Your caregiver can give you a form to complete. It does not have to be notarized or witnessed. You can fill out all or part of the form, based on your needs.
2) **Verbally:** New Mexico law states that patients can tell their physicians what kind of care they want, or who they want the doctor to talk to if they cannot make decisions about their care. However, it also is advisable to document your wishes in writing.

Who can make Advance Directives?

If you are 18 years of age or older and capable of making your own decisions, you can make Advance Directives.

Why should I make Advance Directives?

Advance Directives tell others who you want to make healthcare decisions for you when you cannot and also what care and treatment you do or do not want. They may relieve your family of the burden of guessing what you would want.

Where should I keep my Advance Directives?

Inform your family and friends that you have Advance Directives and keep the original in a safe place at home where it can be easily found. Give a copy to the person you want to make medical decisions for you when you cannot and to your physician, for your permanent medical records. Keep spare copies on hand to give to your caregivers if you go the hospital or other healthcare facility.

Why should I make decisions about my healthcare?

Lovelace Health System supports patients' rights to make decisions about the care they receive and to make Advance Directives for healthcare. Our staff follows New Mexico state law, which gives patients many options to make these decisions.

What you should know about your rights.

- Any competent adult may designate, verbally or in writing, a person who can make healthcare decisions for him or her if he/she cannot do so. If you communicate your healthcare decisions verbally to your physician, your wishes will be documented in your medical record and will be legally binding.
- If you become incapable of making medical choices and have not appointed someone to make them for you, we will follow this "hierarchy of consent" to ensure decisions will be made according to your wishes:
    1) Spouse
    2) The individual with whom you have a long-term relationship
    3) Adult children
    4) Parent
    5) Adult siblings
    6) Grandparent
    7) An adult who knows you and your values

This "hierarchy of consent" means that if the first person is not available – for example, you are not married – the next person would be contacted. If you know who you want as your healthcare agent, tell your caregivers. Also, you should discuss your wishes for medical treatment with this person, so he or she can make decisions according to your wishes.

Lovelace
Women's Hospital

4701 Montgomery Blvd. NE
Albuquerque, NM 87109
lovelace.com

Welcome to Lovelace Women's Hospital,

Thank you for choosing us for this special time in your life. We want to reassure you we are taking aggressive steps to reduce the risk of transmission of the COVID19 virus and are offering a rapid COVID 19/Influenza nasal swab to all patients admitted to OB Services. Testing allows families to know if they will need to take any extra precautions to protect their newborn. Knowing a patient's COVID 19 status helps us to select the appropriate protective equipment while we care for you and protects hospital staff from infection so we remain able to provide the exceptional care you've come to expect.

Thank you for wearing your mask until you receive a negative result and we appreciate your support person wearing their mask whenever staff enters the room.
Please indicate your choice for COVID 19 testing below.

_____I would like to receive a rapid COVID 19/Influenza test.

_____I do not wish to receive a rapid COVID 19/Influenza test.

_____
Patient Signature

Thank you for allowing us to care for you and your family!