(Fill out in the absence of label)

Hospital Name_____

Full Name:_____

Date of birth: ___/___/_____ Age:_____ Gender: ____ Bed: _____

Admission Date: ___/___/_____ Time:_____ Registration:_____

Chief Medical Officer:_____ CRM: _____

AGREEMENT FOR HOSPITAL ADMISSION AND / OR MEDICAL CARE

The patient and / or representative undersigned hereby authorize hospital admission and / or medical care, in accordance with the following provisions:

a) The hospital will provide hospital care to the patient, in compliance with good technique, respecting the organization's internal criteria and through specialized staff, being authorized, as of now, to perform all clinical or surgical procedures recommended, carry out tests and additional diagnostic methods, administer medication and perform, ultimately, all the actions necessary to deliver perfect patient care.

b) During hospital stay, the family members and visitors must meet the standards set in the rules of the organization.

c) Infection in hospital settings are, as we know, often inevitable, despite the efforts adopted. The tools we provide to reduce risks are controls adopted by the Hospital Infection Control Service (SCIH), in addition to a number of measures established by the hospital rules that must be adopted by all, such as: frequent hand washing, avoid sitting on the patient's bed and not eating food that was not provided by the hospital.

d) Smoking is prohibited at all environments of any hospital, under existing legislation.

e) The hospital recognizes that the attending physician is responsible for conducting the treatment administered to the patient, and the performance of the hospital's clinical staff is subject to the guidelines set forth by this physician.

f) Attending physicians are selected by patients as a free choice, and there is no contractual or representative relationship between these physicians and the hospital. These physician's fees are not included in the hospital bill and the hospital does not respond for the acts of those professionals whose technical independence is ensured by the rules governing the medical activity. However, to work at the hospital, every physician must first be registered.

g) If the patient does not have a physician or specialist of preference to conduct the treatment, the hospital can refer one or more qualified professionals, called reference physicians, not necessarily registered under the Health Insurance Provider linked to the patient and that, once accepted by the patient and / or representative, take on the condition of Attending Physicians.

h) In close accordance with Article 39 of the Code of Medical Ethics, the hospital and medical staff do not oppose the holding of second opinion requested by the patient or representative, being understood that the hiring of other medical professionals for an opinion shall be supported by and at the expense of the patient and / or representative.

i) The patient authorizes the identification of his/her name on the room door.

j) The Hospital will share information on the progress of the patient's health condition in person as well as to the individuals appointed by the patient upon his/her permission.

k) The hospital stay, as well as all hospital services, including nutrition services, will be terminated upon discharge. **From this moment on, the hospital allows the patient and companion to stay in the room for a period of up to 01 hour.** After this period, if the room is not cleared, the patient will be charged 01 night fee according to private customer pricing table.

l) The patient and / or personal representative agrees on providing information regarding the patient's health condition, length of stay and recovery to be inserted in a database, with use and purpose restricted to the production of scientific knowledge, respecting the ethical standards of secrecy, confidentiality and anonymity.

m) Hospital expenses will be paid at the time of its closure – whether total or partial.

n) The patient, if health insurance beneficiary, states that he/she has received proper documentation (agreement) from the Insurance Provider, which sets forth the scope offered by this company, as well as limitations and exclusions contained in the contract, **given that the mere provision of authorization for admission does not guarantee full coverage of expenses by the health insurance provider.**

o) This organization has no involvement in the contractual relationship set between the patient and the Health Care Insurance Provider and **if there is a payment refusal by the latter, whether total or partial, the hospital reserves the right to collect the amounts due according to the hospital's pricing table, which is available for consultation in the Administration Department.**

Continued overleaf

p) T**he patient's medical discharge does not mean financial coverage by the Health Insurance Provider, nor complete settlement of medical and hospital bills.** The hospital has the right to make additional collection of any debt verified later.

q) If the service provided by the hospital is for any reason not paid by the Health Care Insurance Provider, it shall be subject to arrears penalty equivalent to 2% (2 percent) of the delayed payment price, interest for late payment of 1% per month on any delay of payment, as well as update by the IGP-M of Getulio Vargas Foundation until the effective date of settlement, according to legislation.

r) The patient / representative states that he/she received at this time, along with the explanations and the guidelines of this agreement, the Guidelines and Patient Rights and Duties Manuals.

s) The parties agree that any dispute arising out of the provision of hospital medical services now set will be processed before the Forum determined by the applicable law.

FILL OUT ONLY IN CASES OF ADMISSION THROUGH THE EMERGENCY DEPARTMENT

Wish to contact the attending physician for treatment follow-up, in compliance with the provisions of item "f" above?

☐ No ☐ Yes Please contact Dr _____ Telephone number: _____

Wish the appointment of a reference physician, as described on the provision of item "g" above?

☐ No ☐ Yes

PATIENT/REPRESENTATIVE:

I state that I have read and I understand and agree with all the information described on this statement.

Location _____ Date Month _____ Year 20_____ Time: _____

Legible name: _____ Signature: _____

Representative relatedness to the patient: _____ CPF (ID number): _____

WITNESS

Legible name: _____ Signature: _____