Patient Name: Date of Birth: Account #

GENERAL CONSENT FOR ROUTINE AND EMERGENCY TESTS, EXAMINATION AND TREATMENT

General Consent – I consent to all exams, routine testing and medical care that the doctor and/or other providers caring for me believe are needed. **I understand that all patients who come to the hospital for care of a potential emergency medical condition will be given a medical screening exam. This exam and needed treatment are offered without regard to insurance or ability to pay**. I accept that the services are given in the least restrictive manner and setting to meet my needs.

I understand the doctors who care for me might not be employees of the hospital. These doctors may be independent doctors who have staff privileges and have agreed to treat hospital patients. If hospitalization is necessary, I may choose a doctor, or one will be chosen for me.

I understand this is a teaching hospital and students and residents may help care for me. I also understand that students and residents may observe my care.

If operations or special procedures are needed, I will be asked by my doctor to give separate informed consent. I accept my care may require the use of a range of medical devices and equipment.

I understand medicine is not an exact science and no guarantees have been made about my treatment or outcome.

I expressly permit Inspira to contact me by using any contact information provided including cellular telephone number.

Safety - I understand that I have a duty to take part in the safe delivery of my care. I agree to provide true and complete information to hospital staff and to report changes in my condition. I will ask questions so that I understand my condition and the care given to me. I agree to follow directions and I agree to accept responsibility for any harm caused by my failure to follow these directions. I will treat my care providers, other patients, and hospital property with courtesy and respect. I will not leave the treatment area without my doctor's consent. I will follow all hospital rules, including not smoking. If I am a smoker, I may ask my doctor for help to manage my cravings.

Right to Refuse - I have the right to refuse any drugs, treatment or procedure. I understand that my refusal may cause a great risk to my health. I accept this risk.

Personal Property - I understand the hospital is not responsible for any money or personal belongings kept by me during my treatment. I should send my belongings home.

Consent to take and share photos and video for treatment including telemedicine, quality review and education - I allow Inspira Health Network Hospitals, agents and employees to record photographs, and video and audiotapes of me for treatment, identification, documentation and/or monitoring of my medical condition. Treatment may include electronically sharing photographs, radiology films, reports and/or 2-way video consultation with providers that are not in the hospital. The images may or may not be recorded. If images are recorded, they may become part of my medical record and may also be used for quality review purposes.

Specimens –I understand that if a healthcare worker has inadvertently been exposed to my blood or body fluids and my medical condition does not allow me to give a timely consent, that such specimens will be tested for infectious disease for the exposed healthcare worker to begin treatment, if necessary.

I agree this hospital may retain, discard, preserve and/or use for scientific or teaching purposes, any specimens or tissue taken from my body during my care.

Labor and Delivery Patients - Your signature on this form is your consent for both you and your baby (or babies) born during this hospital stay.

Agreements for Financial Responsibility and Assignment of Benefits - I authorize payment to the hospital of any hospital insurance benefits payable to me, by the insurance company. This payment may not be more than the balance owed to the hospital after my insurance has paid. I understand I will have to pay the hospital for all charges not covered by my insurance. If my insurer or doctor tells me that care should be given in another clinical setting, is non- emergent, or not covered by my insurance, I may still be treated but I may have to pay for care given. If required, I understand it is my responsibility to obtain a referral and/or authorization and if not obtained, I will be held financially responsible for any fees incurred for these services.

I understand the hospital will bill me for care given by hospital employees and I will receive separate bills from doctors and others who provide care to me that are not employed by the hospital.

I assign and transfer to the hospital and doctors who care for me all benefits of any kind that are payable for hospital care, doctors' care, or other services given to me. Benefits include but are not limited to, all insurance payments, Medicare and/or Medicaid payments, and/or payments payable under an Employer Self- Funded Medical Expense Reimbursement Plan as governed by the Employee Retirement Income Security Act (ERISA). This allows the hospital and doctors who cared for me to act in their own names, and in my place, to accept and collect all payments of any kind that would be payable to me. This allows the hospital to sue any insurer or other responsible party to recover these payments. This does not in any way, reduce, release or otherwise affect my financial responsibility to the hospital for any unpaid hospital, doctor or other charges for my care. This is binding upon my administrators, executors, heirs and successors.

I understand that there are programs available to help those who cannot afford to pay for the services rendered. For Financial Assistance information, please call (856) 575-4780, Monday – Friday, 8:30am – 4:00pm.

Release of Information - I consent to the hospital releasing information about me and my care, including my medical record, to any health care provider, social service agency, or institution providing care to me, including those I am referred to after discharge. I also consent to the hospital's use and disclosure of my personal health information for other hospital-approved purposes like administration, education, utilization review, quality improvement, peer review and to seek payment from health insurance or other responsible parties. The undersigned acknowledges the electronic query and receipt of my medication history from any and all sources.

Privacy Practices - Health Insurance Portability and Accountability Act (HIPAA) – The Notice of Privacy Practices explains how your protected health information (information about you and your medical condition) may be used or disclosed.

☐ I received the Notice of Privacy Practices at a prior visit. I do not want another one.

Registration Clerk and/or Patient/Authorized Party initials: _____ Date: _____

☐ I received a copy of the Notice of Privacy Practices at my visit today.

A copy of the Notice of Privacy Practices is available to view at www.InspiraHealthNetwork.org. You may also request a copy be mailed or emailed to you by contacting the Office of Corporate Compliance at (856)507-7857.

Patient Rights - Under Federal and State law, patients have certain rights and must be informed of them.

☐ I received a copy of my Patient Rights at a prior visit. I do not want another one.

Registration Clerk and/or Patient/Authorized Party initials: _____ Date: _____

I have been informed by the hospital of my rights as a patient. I understand that I may obtain a copy of my rights at any registration area in addition to reviewing my rights in the Patient Handbook that will be given to me upon admission and/or placement into an observation bed. I can also view more information regarding Patient Rights by visiting www.InspiraHealthNetwork.org

I understand that I have the right to present questions or grievances to a hospital staff member by calling (856) 641-7770 for Bridgeton, Elmer and Vineland and (856) 686-5040 for Woodbury. I may also contact the Following agencies with any questions or complaints: **NJ Department of Health & Senior Services at 1 (800)792-9770 and DNV Hospital Accreditation Agency at (866) 496-9647**.

Verification - I certify that the information I have provided about me is correct; this includes my name, date of birth, social security number, current address, current phone number, and current insurance information. I understand that if this information is false and I have given another person's identification or insurance information, the hospital may report me to the police.

I have read, and I understand this **GENERAL CONSENT FOR ROUTINE AND EMERGENCY TESTS, EXAMINATION AND TREATMENT**

My signature means I agree to the above. I may ask for a copy of this form.

☐	_____ **Signature of Patient/Authorized Representative and Relationship**	_____ Time	_____ Date
	_____ **Print Name if Other Than Patient**		

_____ Time	_____ Date	_____ Signature of witness (necessary when the patient is unable to sign this document; when telephone consent is obtained, or when the patient's signature is obtained by someone other than the physician).

☐ Patient unavailable to sign this form ☐ Patient unable to sign this form ☐ Verbal consent given

_____ Time	_____ Date	_____ Staff name if any of the boxes above are checked.

New Jersey Department of Banking and Insurance
NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care - Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

❑ I hereby revoke my consent to representation by **Inspira Health** and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date: _____

Relationship to Patient: ❑ I am the Patient ❑ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX:_____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary. This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____ marking ➢ (or I) and signing below, agree to:

❑ representation by **Inspira Health** in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

❑ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ❑ I am the Patient ❑ I am the Personal Representative (provide contact information on back)

*If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary. This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____ marking ➢ (or I) and signing below, agree to:

❑ representation by **Inspira Health** in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

❑ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ❑ I am the Patient ❑ I am the Personal Representative (provide contact information on back)

*If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

Patient Name:
Patient Number:

q Inspira Bridgeton Health Center 333 Irving Avenue Bridgeton, NJ 08302 856-575-4500
q Inspira Medical Center Elmer 501 West Front Street Elmer, NJ 08318 856-363-1000
q Inspira Medical Center Mullica Hill 700 Mullica Hill Rd Mullica Hill, NJ 08062 856-508-1000
q Inspira Medical Center Vineland 1505 W Sherman Ave Vineland, NJ 08360 856-641-8000
q Inspira Medical CenterWoodbury Health Center 509 N. Broad Street Woodbury, NJ 08096 856-845-0100

Important Message from Medicare

Your Rights as a Hospital Inpatient:

- You can receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- You can be involved in any decisions about your hospital stay.
- You can report any concerns you have about the quality of care you receive to your QIO: **Livanta BFCC** at **1-866-815-5440 or TTY: 1-866-868-2289**. The QIO is the independent reviewer authorized by Medicare to review the decision to discharge you.
- You can work with the hospital to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.
- You can speak with your doctor or other hospital staff if you have concerns about being discharged.

Your Right to Appeal Your Hospital Discharge:

- You have the right to an immediate, independent medical review (appeal) of the decision to discharge you from the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the reviewer will each receive a copy of a detailed explanation about why your covered hospital stay should not continue. You will receive this detailed notice only after you request an appeal.
- If the QIO finds that you are not ready to be discharged from the hospital, Medicare will continue to cover your hospital services.
- If the QIO agrees services should no longer be covered after the discharge date, neither Medicare nor your Medicare health plan will pay for your hospital stay after noon of the day after the QIO notifies you of its decision. If you stop services no later than that time, you will avoid financial liability.
- If you do not appeal, you may have to pay for any services you receive after your discharge date.

See page 2 of this notice for more information.

How to Ask For an Appeal of your Hospital Discharge

- You must make your request to the QIO listed above.
- Your request for an appeal should be made as soon as possible, but no later than your planned discharge date and before you leave the hospital.
- The QIO will notify you of its decision as soon as possible, generally no later than 1 day after it receives all necessary information.
- Call the QIO **Livanta BFCC at 1-866-815-5440 or TTY: 1-866-868-2289** to appeal, or if you have questions.

If You Miss The Deadline to Request An Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO **Livanta BFCC at 1-866-815-5440 or TTY: 1-866-868-2289** .
- If you belong to a Medicare health plan: Call your plan _____

  at _____

For more information, call 1-800-MEDICARE (1-800-633-4227). or TTY: 1-877-486-2048. CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified of my rights as a hospital inpatient and that I may appeal my discharge by contacting my QIO.

_____ _____

Signature of Patient or Representative Date / Time

Medicare Outpatient Observation Notice

Patient name: **Patient number:**

You're a hospital outpatient receiving observation services. You are not an inpatient because:

- ☐ You need care for < 48 hours; your doctor ordered additional testing to determine if you should be admitted or discharged and/or your Medicare Advantage plan approved observation care for your continued services.
- ☐ Other _____

Being an outpatient may affect what you pay in a hospital:

- When you're a hospital outpatient, your observation stay is covered under Medicare Part B.
- For Part B services, you generally pay:
  - A copayment for each outpatient hospital service you get. Part B copayments may vary by type of service.
  - 20% of the Medicare-approved amount for most doctor services, after the Part B deductible.

Observation services may affect coverage and payment of your care after you leave the hospital:

- If you need skilled nursing facility (SNF) care after you leave the hospital, Medicare Part A will only cover SNF care if you've had a 3-day minimum, medically necessary, inpatient hospital stay for a related illness or injury. An inpatient hospital stay begins the day the hospital admits you as an inpatient based on a doctor's order and doesn't include the day you're discharged.
- If you have Medicaid, a Medicare Advantage planor other health plan, Medicaid or the plan may have different rules for SNF coverage after you leave the hospital. Check with Medicaid or your plan.

NOTE: Medicare Part A generally doesn't cover outpatient hospital services, like an observation stay. However, Part A will generally cover medically necessary inpatient services if the hospital admits you as an inpatient based on a doctor's order. In mot cases, you'll pay a one-time deductible for all your inpatient hospital services for the first 60 days you're in a hospital.

If you have any questions about your observation services, ask the hospital staff member giving you this notice or the doctor providing your hospital care. You can also ask to speak with someone from the hospital's utilization or discharge planning department.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your costs for medications:

Generally, prescription and over-the-counter drugs, including "self-administered drugs," you get in a hospital outpatient setting (like an emergency department) aren't covered by Part B. "Self- administered drugs" are drugs you'd normally take on your own. For safety reasons, many hospitals don't allow you to take medications brought from home. If you have a Medicare prescription drug plan (Part D), your plan may help you pay for these drugs. You'll likely need to pay out-of- pocket for these drugs and submit a claim to your drug plan for a refund. Contact your drug plan for more information.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO) or other Medicare health plan (Part C), your costs and coverage may be different. Check with your plan to out about coverage for outpatient observation services.

If you're a Qualified Medicare Beneficiary through your state Medicaid program, you can't be billed for Part A or Part B deductibles, coinsurance, and copayments.

Additional Information (Optional):

When you're a hospital outpatient, your observation stay is covered under Medicare Part B and if you have a supplemental insurance plan, they usually pay the 20% copayments, not covered by Medicare.

If you're enrolled in a Medicare Advantage plan (like an HMO or PPO), the copayments noted above may not apply to you. Please check with your plan about coverage for outpatient observation services.

Inspira Health has chosen not to bill you for medications received while you are in observation.

If you have questions, please contact Care Coordination at 856-641-7802 Elmer/Vineland or Mullica Hill/Woodbury at 856-508-1468. Questions/information regarding Financial Assistance, call 856-641-6336

Patient/Representative Refused to Sign Notice but Copy Was Provided to Them

_____ _____

Hospital Witness/Title Date and Time

Please sign below to show you received and understand this notice.

_____ _____

Signature of Patient or Representative Date / Time

CMS does not discriminate in its programs and activities. To request this publication in alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

A Guide to Outpatient Observation for Non-Medicare Patients

Patient name: _____ **Patient Signature:** _____

Patient number: _____ **Staff Name:** _____ **Date:** _____

You're a hospital outpatient receiving observation services, not an inpatient because:
You need medical care for < 48 hours; your doctor ordered additional testing to determine if you should be admitted or discharged and/or your insurance plan approved observation care for your continued services.

1. **What is outpatient observation?**
   Observation is a special service or status that allows physicians to place a patient in an acute care setting, within the hospital, for a limited amount of time to determine the need for inpatient admission. Patients are monitored by the hospital's nursing staff while in observation. Once medically stable, discharge will occur.

2. **What is the difference in billing?**
   Observation stay is billed as an outpatient service. Outpatient observation status may impact coverage determinations made by your insurance company for hospital care as well as care done immediately after your hospitalization. You should contact your insurance company for specific guidelines.

3. **What kind of problems do people have that would make observation appropriate?**
   There are many types of clinical problems that would support the need for observation, such as symptoms that can usually be resolved within 24-48 hours or where the need for admission is unclear. The intent of Observation is to allow a physician more time to evaluate/ treat a patient and to make a decision to admit or discharge.

4. **What are some examples of these problems?**
   Examples could include nausea, vomiting, stomach pain, headache, fever, and some types of shortness of breath and chest pain.

5. **What is meant by a "limited amount of time"?**
   Observation is only appropriate for short time periods, usually no more than 48 hours.

6. **What happens at the end of the observation stay?**
   Typically, your physician will decide whether to discharge you to home or admit you as an inpatient. Discharge may occur at any time of day.

7. **What if my physician decides my condition requires acute inpatient care?**
   When the determination is made, your physician must then write an order to convert your outpatient observation stay to an inpatient admission. At that time, you may be moved to a different area of the hospital or remain where you are.

8. **What if my physician decides that I do not require acute inpatient care?**
   Your physician will discharge you, and your PCP will have the opportunity to provide you with follow-up care. We will assist you as needed with scheduling your outpatient follow-up services.

9. **How does observation care affect the way my insurance plan covers my care in a skilled nursing facility?**
   You should check with your insurance plan to see if they require a qualifying hospital stay.
   - A qualifying hospital stay means you've been a hospital patient for at least three days in a row (counting the day you were admitted as an inpatient, but not counting the day of your discharge).

For questions regarding observation care call Care Coordination staff at Vineland, 856-641-7802, Elmer, 856-363-1812 and Mullica Hill, 856-508-1468 or for information regarding Financial Assistance, call 856-641-6336