Behavioral Health Center

Conditions of Admission

Please indicate that you understand and agree to the following by initialing next to each statement.

_____ I consent to both psychiatric and medical treatment.

_____ I consent to be photographed (for identification purposes only). Pictures will be used in the medical record and on the medication cart only. Pictures will be retained after discharge as part of the permanent medical record.

_____ I pledge to honor the confidentiality of all patients at the EIRMC Behavioral Health Center. I understand that I am not to reveal to anyone the identity of patients nor discuss any situation I may become aware of while at this facility.

_____ I understand and agree that the use of reasonable restraint and/or confinement may be necessary in order to prevent harm to myself, others, or hospital property. I understand and agree to release from liability the hospital, staff, or physician who may be in attendance should any loss or injury occur as a result of such restraint and/or confinement.

_____ I authorize the hospital to disclose and list my first name and my physician's last name on a census board located at a nurse's station, on nursing report sheets and medication drawers. I understand that the purpose of this is to assist physicians, nursing staff, and ancillary services in locating me in a timely manner for care and treatment. I release the hospital, it's employees, and physicians from any responsibility arising from this disclosure. I have been given the option to refuse permission for this disclosure.

_____ I understand that Recreation Therapy will be part of my treatment during my stay at BHC. I understand that some of these groups may be physical in nature and I agree to inform staff of any physical limitations that may prevent me from participating safely in these activities.

_____ I have received the pamphlet entitled "Your Patient Rights & Responsibilities" and understand the BHC grievance process as it has been explained to me.

Patient/Authorized Representative Signature _____ date _____

Relationship of Authorized Representative to Patient _____

BHC Staff Signature _____ date _____ time _____