In this document, "**Patient**" means the person receiving treatment. "**Patient Representative**" means any person acting on behalf of the Patient and signing as the Patient's representative. Use of the word "I," "you," "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I" or "me" may also, depending on the context, mean financial guarantor "Guarantor".

"**Provider**" means the facility and may include healthcare professionals on the facility's staff and/or hospital-based physicians, which include but are not limited to: Radiologists, Emergency Department Physicians, Pathologists, Hospitalists, Anesthesiologists, as well as certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf.

1. **Consent to Treatment.** I consent to the procedures that may be performed during this episode of care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, x-ray and other imaging examinations, diagnostic procedures, or other medical, nursing or surgical treatment or procedures, anesthesia, or hospital services / hospitalization rendered as ordered by the Provider. I consent to allowing residents and other supervised individuals enrolled in a healthcare professional education program as part of their training in health care education to participate in and/or observe the delivery of my medical care and treatment. I further consent to the Provider conducting blood-borne infectious disease testing, including but not limited to, testing for hepatitis, Acquired Immune Deficiency Syndrome ("**AIDS**"), and Human Immunodeficiency Virus ("**HIV**"), if a Provider orders such tests or if ordered by protocol. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.

2. **Consent to Treatment Using Telemedicine.** I consent to treatment involving the use of electronic communications ("**Telemedicine**") to enable health care providers at different locations to share my individual patient medical information for diagnosis, therapy, follow-up, and/or education purposes. I consent to forwarding my information to a third party as needed to receive Telemedicine services, and I understand that existing confidentiality protections apply. I acknowledge that while Telemedicine can be used to provide improved access to care, as with any medical procedure, there are potential risks and no results can be guaranteed or assured. These risks include, but are not limited to: technical problems with the information transmission or equipment failures that could result in lost information or delays in treatment. I understand that I have a right to withhold or withdraw my consent to the use of Telemedicine in the course of my care at any time, without affecting my right to future treatment and without risking the loss or withdrawal of any program benefit to which I would otherwise be entitled.

3. **Consent to Medication Not Yet FDA Approved and/or Medication Prepared/Repackaged by Outsourcing or Compounding Pharmacy.** As part of the services provided, you may be treated with a medication that has not received FDA approval. You may also receive a medication that has been prepared or repackaged by an outsourcing facility or compounding pharmacy. Certain medications for which there are no alternatives or which your physician recommends may be necessary for potentially life-saving treatment.

4. **Consent to Photographs, and Video, Digital and Audio Recordings.** I acknowledge that the facility's security, quality improvement, patient care, healthcare operations and/or risk management act ivities may involve photographs, video, digital or audio recordings, and/or other images of me, including telephone calls, being recorded and consent to such images and recording. I understand that the facility retains the ownership rights to the images and/or recordings. Images and/or recordings in which I am identified will only be used and disclosed as permitted by law.

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5. **Financial Agreement.** I understand that the facility may bill an insurance company offering coverage. Regardless, in consideration for the services rendered and except where prohibited by law, I (the Patient or Guarantor) agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements. I understand that in the event any amounts paid by me are ultimately greater than my final patient responsibility, such amounts may be applied to patient responsibility on other unresolved accounts prior to refund. I understand that while an estimate may have been provided prior to services, estimates may vary significantly from final charges based on a variety of factors. An itemized billing statement is available upon request and free of charge.

   If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the facility may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor will be determined by the terms of the governmental program or private health insurance plan. If the Patient is uninsured and not covered by a governmental program, the Patient may be eligible to have his or her account discounted or forgiven under the facility's uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the facility.

6. **Professional services rendered by independent contractors and Advanced Practice Professionals are not part of the facility bill.** I understand and acknowledge that the physicians and advanced practice professionals providing services to me in the facility are independent contractors and not agents or employees of the facility. I understand that I may not actually see, or be examined by all physicians or other advanced practice professionals participating in my care; for example, I may not see my treating physicians/ surgeons, radiologists, pathologists, cardiologists, emergency physicians, anesthesiologists, staff physicians, contract physicians, physician assistants and other advanced practice professionals including those providing radiology, pathology, EKG interpretation, anesthesiology services or telemedicine. I understand that, in most instances, there will be a separate charge for professional services rendered by these providers and that I will receive a bill for these professional services that is separate from the bill for facility services.

7. **Legal Relationship between Hospital and Physicians and Advanced Practice Professionals.** Independent physicians and advanced practice professionals are responsible for their own actions and the facility shall not be liable for the acts or omissions of any such independent physicians and/or advance practice professionals. To the extent that any duty to perform any care, procedure, service and/or treatment is imposed upon the facility, the responsibility for the performance of such care, procedure, service and/or treatment is delegated to the applicable healthcare professionals.

8. **Assignment of Benefits.** Patient assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization or for outpatient services, including emergency services, if rendered. I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

I hereby **irrevocably appoint** the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies for any and all benefits due me for the payment of charges associated with services and treatment rendered by the Provider. These authorized actions include administrative and non-administrative appeals of any denial or underpayment of benefits or coverage, litigation, other forms of dispute resolution in any forum or for any type of relief (including monetary and equitable) available under applicable laws, including without limitation all provisions of the Employee Retirement Income Security Act of 1974, on my behalf against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party ("**Responsible Party**"). I also transfer and assign to the Provider all of my rights to demand and receive the production of or access to any documents or information, including without limitation, copies of health plan documents and materials, from any entity or person to the fullest extent of my rights to do so under my health plan and applicable laws. The foregoing rights are assigned in their entirety without limitation and without reservation of any part or aspect thereof. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

9. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII ("**Medicare**") or Title XIX ("**Medicaid**") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.

10. **Outpatient Medicare Patients.** Medicare does not provide coverage for "self-administered drugs" or drugs that you normally take on your own, with only a few limited exceptions. If you get self-administered drugs that aren't covered by Medicare Part B, we may bill you for the drug. However, if you are enrolled in a Medicare Part D Drug Plan, these drugs may be covered in accordance with Medicare Part D Drug Plan enrollment materials. If you pay for these self-administered drugs, you can submit a claim to your Medicare Part D Drug Plan for a possible refund.

11. **Communications About My Healthcare.** I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care. I will provide those individuals with a password or other verification means specified by the facility. I agree I may be contacted by the Provider or an agent of the Provider or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

12. **Consent to Telephone Calls, Email or Text Message.** I authorize the use of any email address or telephone number I provide (including email addresses or telephone numbers that I provide for my family or designated representatives) (whether wireless or a landline and including email addresses and telephone numbers forwarded or transferred from provided information) for receiving information relating to my healthcare services and financial obligations, including, but not limited to: (i) healthcare-related information, including appointment reminders, discharge instructions, pre-operative or post-operative instructions, follow-up instructions, dietary information, prescription information, referrals, insurance or health plan eligibility or coverage, follow-ups related to a visit or other interaction, information about my condition(s), diagnosis, treatment plan, available

treatment options and capabilities, reference materials, information about programs or services that might be of interest to me, invitations to participate in surveys, reviews or evaluations of my experience(s), instructions for how to access my information or records, or inquiries regarding my preferences; and (ii) financial communications, including without limitation, financial assistance and benefits screening, payment reminders, delinquent notifications, instructions, and links to facility Patient billing information.

I expressly agree and consent that you or your customer service personnel and collection agents may contact me by telephone, on a recorded line and/or using automated dialing technology, at any telephone number I have provided or you or your customer service personnel and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the hospitalization, the services rendered, or my related financial obligations. I represent (if I am not the patient) that I am authorized by the patient to receive calls, text messages or email messages on their behalf and that I am involved in assisting in the patient's care and/or payment. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable. I represent that I am the account holder for any telephone number(s) that I may provide and am responsible for notifying Provider of any changes or updates to such telephone number(s).

I understand that emails and text messaging are unencrypted and that there is some risk that information included in unencrypted messages, including email and text messages, may be intercepted or received by unintended third parties and/or stored or archived by our service providers and system operators. Information included in such messages may include your name, date/time of appointments, physician/practice name, physician/practice specialty, patient account number or other information related to your financial obligation or our services. Message and data rates may apply to text messages. Additional text messaging terms may be located on the Provider's website and may be updated from time to time. To stop receiving a certain text message type (e.g., subsequent messages about my treatment plan), I understand that I can follow the optout instructions included in the message that I wish to opt out from receiving additional messages of such type, but I may continue receiving text messages of other types subject to separate opt-out procedures.

13. **Use and Disclosure of Information.** I consent to Providers using and disclosing health information about me for purposes of treatment, payment, healthcare operations public health and other purposes permitted by applicable law. Information covered by this consent specifically includes, without limitation, history and physical records, emergency records, laboratory reports, physician progress notes, nurse notes, discharge summaries, genetic information, psychological information, psychiatric information, intellectual disability information, and information about substance abuse disorder and chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS. This consent applies, without limitation to uses and disclosures for coordinate care or for case management purposes; to any person or entity liable for or involved in payment on Patient's behalf including to verify coverage; and to my employer's designee when the services delivered are related to a worker's compensation claim. If I am covered by Medicare or Medicaid, I authorize the release of my healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. Provider participates, or may in the future participate, in Health Information Exchanges (HIEs) or other organizations with healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order to share health information for treatment, payment, health care operations and other purposes permitted by law. Unless I notify Provider in writing that I desire to opt out of participation, I consent to health information about me being shared with participants in HIEs and other organizations as described above.

14. **Other Acknowledgements.**

Personal Valuables. I understand that the facility shall not be liable for the loss of or damage to any of my property (regardless of whether placed in lockers, etc.) unless deposited with the facility specifically for safekeeping in a facility controlled safe where available. The liability of facility for loss of any personal property deposited specifically with the facility for safekeeping is limited to the minimum required under applicable law.

Weapons/Explosives/Drugs. I understand and agree that if the facility at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage on my person or with my belongings, the facility may search for, confiscate and dispute of any of the above items, including delivery of any item to law enforcement authorities.

Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my Patient Representative designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity and gender expression, and sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the facility may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other Patients. The facility will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the facility's complaint resolution system.

Additional Provision for Minors/ Incapacitated Patient. If I am signing as legal guardian, I acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

15. **Notice of Privacy Practices.** I acknowledge that I have received the facility's Notice of Privacy Practices, which describes the ways in which the Provider may use and disclose my health information. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. I understand that I may contact the facility Privacy Officer designated on the notice if I have a question or complaint.
Acknowledge: _____ (Initial)

16. **Acknowledgement of Notice of Patient Rights and Responsibilities.** I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law. I understand that I can provide an advance directive to the Provider, and I can request information about formulating an advance directive at registration or thereafter.
Acknowledge: _____ (Initial)

17. **Acknowledgement:** I have been given the opportunity to read and ask questions about the information contained in this form, **specifically** including but not limited to the financial obligation's provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.
Acknowledge: _____ (Initial)

Date:	I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian, hereby certify I have read, and fully and completely understand this Conditions of Admission and Consent for Outpatient Care, and that I have signed this Conditions of Admission and Consent for Outpatient Care knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.
Time	

Patient/Patient Representative Signature:

X_____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Neighbor/Friend
- ☐ Sibling
- ☐ Healthcare Power of Attorney
- ☐ Guarantor
- ☐ Other (please specify): _____

Witness Signature and Title:

X_____

Additional Witness Signature and Title:
(required for Patients unable to sign without a representative or Patients who refuse to sign)

X_____

Standard OP 10/7/22

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