FACILITY CARE CONSENT

1. **General Consent:** I consent to the rendering of medical care which may include diagnostic testing (such as labs and x-rays), injections, immunizations, medications, and such other medical treatment as my attending or other physician(s) consider to be necessary at Santa Rosa Hospital - Medical Center ("Facility"). I have the right to discuss treatment and procedures with the physician beforehand. I have the right to consent or refuse any treatment. Some medical services may be offered via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different location, and I consent to such services. I understand that medicine is not an exact science. No one has guaranteed me results. The medical care I receive while in the Facility may be under the direction of an independent provider, who is not an employee of the Facility. The Facility is not responsible for the medical care, medical judgment, and plan of care provided by non-employees.

2. **COVID-19:** I acknowledge that Coronavirus 2019 (COVID-19) is a novel virus that spreads easily among people, and has spread within this area and throughout the state, and nearby states. Much is still being discovered about this virus, but data has shown it spreads when someone with the virus talks, coughs, or sneezes and the respiratory droplets released into the air are inhaled or on a surface touched by another person. As such, I understand that I may be exposed to and acquire this disease anywhere, and that avoidance of transmission is extremely difficult to control perfectly in any environment. However, I understand that the Facility has implemented numerous safety measures designed to protect me and others from exposure to the virus, and I agree to comply with all such Facility requirements. I agree that I have advised the Facility personnel of any potential symptoms of COVID-19 I or anyone I live with is currently experiencing, as well as any known exposure to other persons who are believed to have the virus.

3. **Personal Property:** I understand that I am responsible for my personal property while at the Facility. The Facility is not responsible for keeping my property safe.

4. **Financial Assistance:** If I cannot afford my Facility medical bills, I may be eligible for charity care or other adjustments. I have been offered a paper copy of the Facility's plain language summary of its Financial Assistance Policy. The full policy and more information are available at www.christushealth.org/charitycare.

5. **Release of Information:** I allow the Facility to release health information for payment purposes and other reasons allowed by law. The law allows the release of my information to other providers for my care as written in the Facility's Notice of Privacy Practices. I agree that all records about my treatment are the Facility's property. I understand that medical records and billing information created or maintained by the Facility are available to Facility workers, volunteers, allied health professionals, and medical staff. These persons may use and disclose my medical information for treatment, payment, and healthcare operations.

6. **Medicare/Medicaid Benefits:** If applicable, 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 or its intermediaries any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services. If I have Medicare/Medicaid, my financial obligations may be limited by law.

7. **Communication:** I authorize the Facility (including any billing service, collection agency, agent, or contractor on the Facility's or contractor's behalf) to contact me by phone at any number that I have provided to the Facility at any time. The Facility may also contact me at any number it may obtain for me in the future, including cell phone numbers, which could result in charges to me. The Facility may use pre-recorded or artificial voicemail messages and the use of an automatic dialing device or automated telephone dialing systems. The Facility may send me voicemail messages, text messages, or e-mails. I allow the Facility to contact me using any e-mail address that I have given it or any e-mail addresses that the Facility may obtain for me in the future.

X __________Patient Initials

FACILITY CARE CONSENT

8. **Testing After Accidental Exposure and State Reporting:** If a healthcare worker accidentally touches my blood or other body fluids, state law allows the Facility to test me for certain diseases. These diseases include human immunodeficiency virus (HIV). These tests are conducted to protect healthcare workers. I will not be charged for such tests. I understand that the Facility is required by law to report certain infectious diseases, such as HIV and tuberculosis, to the state health department or Centers for Disease Control.

9. **Photography:** I consent to the Facility videotaping, photographing, video monitoring, or taking other recordings of me or parts of my body for diagnosis, treatment, research, or patient safety purposes. These recordings might be used for quality improvement, treatment or operations, or deidentified for medical education or research. I will talk with my doctor if I do not want my recordings used for these purposes.

10. **Ethics:** The Facility is a Catholic health ministry dedicated to helping the sick and injured in compliance with the *Ethical and Religious Directives for Catholic Health Facilities*. The Facility may not be used for procedures that violate the directives.

11. **Teaching and Observation:** I understand that the Facility may be a teaching facility. I consent to medical residents and fellows who have a formal affiliation with the Facility to participate in my care as supervised by the treating providers and permitted by Facility policy. Students, residents, and fellows and those from other non-affiliated programs, as well as vendors may observe my care consistent with Facility policy and as approved by my treating physician.

12. **Assignment of Benefits:** I hereby assign payment otherwise payable to me from governmental payers (such as Medicare), insurance carriers, employee health benefit plans and other third-party payers (collectively referred to as "Plans") to Facility and other health care providers who provide services, care or treatment to me at the Facility.

    I acknowledge that I am responsible for knowing the limitations of my Plan benefits and understand that I may be personally responsible for paying the charges billed for services, care or treatment that my Plan deems to be: (i) not a covered benefit; (ii) in excess of the Plan's benefit limitation; or (iii) not medically necessary, investigational or experimental.

    The Facility will make a reasonable effort to verify my Plan's coverage for the services, care and treatment I expect to receive at the Facility and to notify me, in advance, of items it knows are not covered benefits. However, should my Plan ultimately deny payment for the services, care and treatment provided to me by the Facility and its health care providers, I am responsible for paying the billed charges for such items, consistent with applicable law, applicable contractual discounts and the Facility's patient financial assistance policies. Upon request, an authorized Facility representative will be made available to explain eligibility for financial assistance under such policies.

    If the Facility refers my account for collection, I will be responsible for paying the cost of collection, including reasonable attorneys' fees, expenses and interest as allowed by law.

    Professional services rendered by independent physicians or healthcare professionals may not be part of the Facility bill. In many instances, there will be a separate charge for professional services you receive at the Facility, and you will receive a separate bill for these professional services in addition to the bill for Facility services. Please understand that you may not actually see or be examined by all physicians or healthcare professionals who participate in your care or provide services to you or on your behalf. For example, you may not see physicians providing radiology, pathology, and EKG interpretation.

X __________Patient Initials

FACILITY CARE CONSENT

13. **Patient Rights and Advance Directives:** The Facility provided me a copy of the Patient Rights and Responsibilities when I arrived to the Facility. I also understand that I can request an additional copy any time. The Patient Rights and Responsibilities includes information about advance directives, my right to refuse medical treatment, and my right to have visitors or name someone who can exercise patient visitation rights on my behalf, if I cannot. If I give the Facility an advance directive, my caregivers will follow it to the extent allowed by law. I also have the right to consent to a DNR order, I can change my mind about DNR orders at any time. I have the right to know if my doctor makes changes to orders about resuscitation.

14. **Notice of Privacy Practices:** I have been offered a copy of the Facility's Notice of Privacy Practices at this or an earlier visit. The Facility will give me a copy of the Notice of Privacy Practices any time I ask for one.

15. **Insurance Information:** I have provided the Facility with complete and correct insurance information, which includes any primary, secondary, and tertiary insurance plan and any responsible party that could be responsible for payment of services provided by the facility. I have, to the best of my knowledge, communicated the appropriate filing order for all insurance plans and responsible parties provided.

16. **Health Information Exchange and Physician Messaging**: This provider participates in Health Information Exchanges (HIEs) and physician messaging. HIEs are electronic systems that allow health care providers to share information about patients. HIEs give information (like your allergies, medicines, and test results) from other doctors or Facilities to your current provider. The information may help your provider make more informed treatment decisions. The HIE also helps you receive efficient care because your health information is more easily available to providers when they need it. You have the right to choose if you want to participate in the HIE. Your information will be stored within the CHRISTUS HIE system, but it will not be visible to non-CHRISTUS providers unless you choose to participate. Your treatment is not conditioned on your decision. You can access medical care at CHRISTUS whether or not you participate in the HIE. You may change your decision at any time by notifying the Facility admitting staff and completing a new authorization form. Physician messaging is a CMS requirement that requires a Facility, if no objection is communicated by the patient, to advise a patient's primary care provider of any admission, transfer, or discharge into the facility via a direct messaging address that is established by the provider and provided to the facility for this purpose.

→ ______ **Yes, I authorize the release of my medical information through the Health Information Exchange and Physician Messaging.** I allow the HIE to share my health information. I understand this may include information created both before and after the date I sign this form. I understand that my medical records are confidential. They cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed by this authorization may be subject to re-disclosure to the extent permitted by applicable laws. I understand that my health information in the HIE may include: genetic information (including genetic test results), substance abuse records, mental illness records, or communicable disease status, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). OBSTETRIC PATIENTS ONLY: I authorize the HIE to include information about any child/children born to me during this hospitalization.

OR

→ ______ **No, I do NOT authorize the release of my medical information through the Health Information Exchange or Physician Messaging.** I do not want my information to be shared through the HIE. I understand that my providers may have less information about me when making decisions about my care. If I decide to participate in the HIE at other participating providers, they will not receive information from CHRISTUS unless I submit a new copy of this form and authorize the release of my CHRISTUS medical information

TEXAS ONLY: Texas law requires all health care providers to notify patients that we must collect statistics on services performed by CHRISTUS. We submit that information to the Texas Healthcare Information Collection program. You cannot opt out of this data collection, but the data will not personally identify you. Additional information is provided to you on the *Texas Department of State Health Services Patient Notification of Data Collection* form or you may contact the State Department at 512-776-7261 or www.dshs.state.tx.us/thcic.

X __________Patient Initials

Facility Care Consent

17. <u>Facility Directory:</u> Unless I object, the Facility will include my name, location in the facility (room number), and general condition in the Facility Directory. Directory information is available to callers or visitors who ask for patients by name. Directory information and religious affiliation (if provided to Facility) are available to clergy members even if they do not ask for patients by name. If I object, I will be excluded from the Facility Directory.

X ***(If you object, initial below.)***

______ I ***DO NOT*** want any information about me to be included in the Facility Directory. I understand that mail, flowers, telephone calls, and visitors will be refused on my behalf because Facility staff cannot acknowledge my presence in the Facility. If I make phone calls from the Facility, caller ID may show call recipients that I am calling from the Facility.

<u>ACKNOWLEDGEMENT:</u> By signing below, I certify that I have read this document, understand its contents, and agree to the terms. I acknowledge that I am the patient or I am the patient's legally authorized representative and/or guarantor. A photocopy or a faxed copy of this consent shall be deemed as valid as the original.

______________________________ ______________

Signature of Patient/Legally Authorized Representative **Date**

X

____

Patient's Name Printed

______________________________ ______________

Name of Legally Authorized Representative (if not Patient) **Relationship to Patient**

______________________________ ______________

Facility Representative **Date**

______________________________ ______________

Facility Representative (Secondary Witness if Needed) **Date**