

## CONSENT FOR TREATMENT

- 1. Consent for Treatment.** The patient is under the control of his attending physician(s) and Ascension St. Vincent's, hereafter referred to as "the Facility", is not liable for any act or omission in following the instructions of said physician(s). The undersigned consents to any x-ray examination, laboratory procedures, anesthesia, medical or surgical treatment or any other diagnostic or therapeutic treatment or hospital services rendered the patient under the general or special instructions of the physician(s). The undersigned also consent to the admission of observers to the room where procedures, tests or examinations are performed and to the disposal of any tissue or specimens removed in accordance with the Facility's practice.
- 2. Release of Medical Information.** The undersigned authorizes the Facility to release information and/or copies of his medical records to physicians, any guarantor of payment on his accounts, insurance companies (and other third party payors, including workers' compensation carriers and the patient's employer) for which he has assigned benefits for his treatment and care. This includes authorization to release information pertaining to: **(i) psychiatric and/or psychological care, alcohol and/or substance abuse, serologic test results (including, but not limited to Acquired Immune Deficiency Syndrome (AIDS) or HIV test results), (ii) care and treatment for this period of illness and (iii) disclose all or part of my medical record to past and future medical care providers.** Such medical care providers may discuss with the Facility and its representatives any treatment provided, procedures performed and complications arising therefrom, if any. I also authorize the Facility to release my social security number and any other requested information to manufacturers or governmental agencies as required by the Safe Medical Devices Act of 1990.
- 3. Independent Health Care Providers. PHYSICIANS, SURGEONS, PODIATRISTS, PSYCHOLOGISTS, PSYCHIATRISTS, DENTISTS, PATHOLOGISTS, ANESTHESIOLOGISTS, RADIOLOGISTS, PHYSICIAN ASSISTANTS, PERFUSIONISTS, NURSE PRACTITIONERS, NURSE MIDWIVES, AND SIMILAR PROVIDERS ("INDEPENDENT HEALTH CARE PROVIDERS") PROVIDING HEALTH CARE SERVICES TO THE PATIENT ARE INDEPENDENT CONTRACTORS AND ARE NOT EMPLOYEES OR AGENTS OF THE FACILITY.**

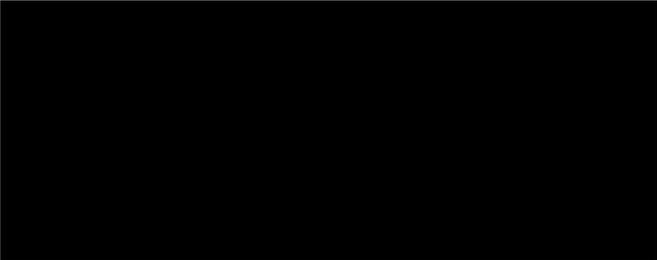
**THE PATIENT ACKNOWLEDGES, UNDERSTANDS, AND AGREES THAT:**

- (A) THE FACILITY IS NOT EITHER EXPRESSLY OR IMPLIEDLY UNDERTAKING ANY DUTY TO THE PATIENT TO PROVIDE ANY HEALTH CARE SERVICES TO THE PATIENT AS MAY BE PROVIDED BY INDEPENDENT HEALTH CARE PROVIDERS;**
- (B) THE PATIENT IS UNDER THE CONTROL OF THE INDEPENDENT HEALTH CARE PROVIDERS, AND THE FACILITY HAS NO CONTROL OVER THE INDEPENDENT HEALTH CARE PROVIDERS WITH RESPECT TO THE HEALTH CARE SERVICES PROVIDED TO THE PATIENT;**
- (C) THE FACILITY IS NOT LIABLE FOR THE ACTS OR OMISSIONS OF THE INDEPENDENT HEALTH CARE PROVIDERS OR FOR FOLLOWING THE ORDERS AND INSTRUCTIONS OF SUCH INDEPENDENT HEALTH CARE PROVIDERS; AND**
- (D) THE PATIENT HEREBY EXPRESSLY CONSENTS TO THE FACILITY'S DELEGATION TO THE INDEPENDENT HEALTH CARE PROVIDERS OF ANY DUTY ON THE PART OF THE FACILITY TO THE PATIENT TO PROVIDE ANY HEALTH CARE SERVICES AS MAY BE PROVIDED BY THE INDEPENDENT HEALTH CARE PROVIDERS AND HEREBY DISCHARGES THE FACILITY FROM ANY DUTY THE FACILITY HAS TO PROVIDE AND/OR ANY LIABILITY FOR PROVIDING OR FAILING TO PROVIDE HEALTH CARE SERVICES AS MAY BE PROVIDED BY THE INDEPENDENT HEALTH CARE PROVIDERS.**

**PATIENT/REPRESENTATIVE INITIALS \_\_\_\_\_**

Further, the patient acknowledges and understands that various Independent Health Care Providers, such as pathologists and radiologists, may provide necessary health care services to the patient at the Facility without direct contact with the patient, and, by accepting services at the Facility, the patient consents to the provision of health care services by such Independent Health Care Providers. Some Independent Health Care Providers also provide oversight and supervision to various departments of the Facility, such as pathologists overseeing the Facility's laboratory. Although such individuals may not have personally rendered services to the patient or reviewed any of the patient's test results, such individuals' supervision is necessary in order to ensure the patient's test results are clinically reliable and are reported to the ordering physician in a timely manner. By accepting health care services at the Facility, the patient agrees that such individuals may bill the patient or the patient's insurance in their usual and customary manner for such health care services and the patient's share of the cost of such professional oversight and supervision.

- 4. Education Acknowledgement.** I acknowledge and understand that one of the activities of the Facility is the training and teaching of healthcare professional, including but not limited to, doctors, nurses and other paramedical personnel.
- 5. Itemized Patient Bill.** Upon request, every Hospital patient has the right to receive an itemized bill for services rendered.
- 6. Medicare Patients.** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct to the best of my knowledge. I authorize the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefit be made on my behalf. I understand that the care and services received during my stay are subject to professional medical review according to the Federal Law P.L. 97-248, and that the information regarding my stay and treatment including, **psychiatric and/or psychological care, alcohol and/or substance abuse, serologic test results (including, but not limited to, Acquired Immune Deficiency Syndrome (AIDS) or HIV test results)** may be forwarded to the Florida Medical Quality Assurance, Inc. PRO, or any successor or entity, who will ensure the confidentiality of information collected and maintained for purposes of professional review.
- 7. Agreement to Pay Charges.** Even if the total reimbursement to the Facility is in excess of the customary charges, by signing in the space below, the undersigned promises to pay to the Facility the customary charges, on demand, for services rendered or any co-payments or deductible for which the undersigned is liable. I agree to pay the charges that are listed in the Facility's current billing charge manuals which are available for inspection upon request and incorporated herein by reference.  
  
I also agree that all charges connected with such services not covered by any insurance, program, sponsorship or other third party coverage are due and payable at the time of discharge or discontinuation of treatment. I hereby acknowledge that, if the Facility has agreed to bill my insurance or other third party carrier, it has agreed to do so as a courtesy and that the Facility has the right, should it deem advisable, to demand payment in full from me at any time prior to full payment from any insurance or other third party carrier, unless the Facility and my insurance company or third party carrier have agreed that I will not be billed.



The statement of charges for services performed will be forwarded by the Facility on request. Any monies payable by insurance companies, assigned to and received by the Facility, will be credited to the balance due. The assignment of insurance monies does not alter the undersigned's obligation to pay. The Facility reserves the right to decline further services to the patient without notice, to accept periodic installment payments without waiving its right to demand payment in full as outlined above and the right to assign the monies due under this Agreement.

Any overpayment for the patient may, in the discretion of the Facility, be first applied to any other account(s) with the Facility owed by the patient with any excess being refunded to the proper party in accordance with Hospital policy. Any account balance overpayment of less than \$25.00 is hereby assigned to the Facility. I hereby acknowledge having been told that I may be billed by the Facility or any of its affiliates for services rendered. I further agree that, if I am more than thirty (30) days delinquent in the payment of any bill connected with this treatment, interest on the amount due may accrue at the maximum rate allowed by law. If the delinquent account is referred for collection, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process.

I assign payment for the unpaid charges for certain in-hospital physician services furnished by specialists, any by physicians for whom the Facility is authorized to bill. I understand that Medicare covers a semi-private room rate. In the event that, at my request, a private room is assigned to me I agree to pay the difference between the private room rate and the semi-private room rate.

- 8. **Assignment of Insurance Benefits.** The undersigned hereby assigns to the Facility reimbursement benefits on all insurance policies otherwise payable to him for this hospitalization/treatment. The undersigned authorizes the Facility to submit insurance claims to insurance companies or plan administrators and to apply insurance proceeds to the Facility bill and to make refunds to insurance company for benefits due under the insurance policies.

I hereby assign benefits and authorize direct payment to any in-hospital physician(s) (radiologists, anesthesiologists, pathologists, etc.), and any consulting physicians for their services provided during my hospitalization/treatment at any Ascension St. Vincent's facility. I understand I am financially responsible to these physicians for charges not covered by my insurance company.

The undersigned does hereby authorize the Facility to endorse any checks payable to the undersigned and to apply the same to any account of the undersigned or any account for which the undersigned could be liable.

The undersigned does hereby authorize the Facility or its representative to prepare and submit to his insurance carrier or plan administrator all the insurance claims, forms, questionnaires and all other statements or documents required by the insurance carrier or plan administrator.

- 9. **Fraudulent Information.** The undersigned acknowledges that Section 817.234 of Florida Statutes provides that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

The undersigned further acknowledges that Section 893.13(7)(a)13 of Florida Statutes provides that any person who, with the intent to obtain a controlled substance or combination of controlled substances that is not medically necessary for the person or an amount of a controlled substance that is not medically necessary for the person, obtains or attempts to obtain from a practitioner a controlled substance or a prescription for a controlled substance by misrepresentation, fraud, forgery, deception, subterfuge, or concealment of a material fact is guilty of a third degree felony.

By my signature below I certify the information I provided is accurate and complete. I understand that withholding of information or giving false information could result in non-payment by insurance and/or criminal action.

- 10. **Notice of Privacy Practices.** The patient acknowledges receipt, either at this time or previously, of a copy of Ascension St. Vincent's Notice of Privacy Practices. The undersigned certifies that he/she has read and accepts the foregoing, receiving a copy thereof, and is personally empowered, or is duly authorized by the patient as patient's general agent, to execute the above.

- 11. **Prior Express Consent.** I acknowledge consent for the Facility, its providers and agents, including debt collectors, to place calls to my cellular and/or residential phone using artificial or pre-recorded voice or auto-dialer technologies for any permissible purpose, including debt collections and/or account verification.

- 12. **Personal Valuables.** The Facility maintains a safe for the safekeeping of money and other valuables, and the Facility will not be liable for the loss of, or damage to, any money, jewelry, glasses, dentures, hearing aids, documents, furs, or other articles of personal property unless deposited in the safe. Patients, their family members, or other representatives are responsible for ensuring the patients' valuables are placed in the Facility's safe or are removed from the Facility's premises. Return of patient belongings from the Facility's safe may be accomplished any day between 8:00 a.m. and 4:30 p.m.

PATIENT/REPRESENTATIVE INITIALS \_\_\_\_\_

- 13. **Medication and Medical Device Assistance Program.** The facility can obtain reimbursement for medications and devices. I hereby approve and allow an Ascension Patient Assistance representative to sign these forms on my behalf.

PATIENT/REPRESENTATIVE INITIALS \_\_\_\_\_

- 14. **Interpreter/Translator Services.** I acknowledge and understand the facility offers interpreter/translator services during treatment. At this time I am  Requesting or  Declining interpreter/translator services during my visit.

PATIENT/REPRESENTATIVE INITIALS \_\_\_\_\_

Date and time of Signing \_\_\_\_\_, Hour \_\_\_\_\_, \_\_\_\_\_  
 Patient (or Parent/ Guardian)

\_\_\_\_\_  
 Witness Guarantor (if other than Patient or different from above Guardian)

\_\_\_\_\_  
 Patient Name Relationship to Patient