CONDITIONS OF ADMISSION AND TREATMENT

As a condition of my and/or my guardian's/child's ("I, me") admission and treatment to any health care facility owned, operated, and/or affiliated with BayCare Health System, St. Joseph's Health Care Center, Morton Plant Mease Health Care, St. Anthony's Hospital, BayCare Alliant Hospital, BayCare Laboratories, BayCare Outpatient Imaging, and/or BayCare Outpatient Centers (individually each, and collectively all, the "**Facility**"), I hereby agree to the following:

1. **CONSENT TO CARE AND TREATMENT**. I consent to the care and/or treatment that may be performed during this hospitalization or while I am an outpatient at Facility. This may include, but is not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, drugs and supplies, medical or surgical treatment or procedures, anesthesia, or other inpatient/outpatient services provided to me under the general or special instructions of my treating physician/surgeon. I understand that the practice of medicine and surgery is not an exact science, and that my care and/or treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of any care and/or treatment in the Facility.
2. **INFORMATION AND INFORMED CONSENT**. I will look solely to my treating physician/surgeon for any questions or answers regarding my care and/or treatment, and it is my treating physician/surgeon's sole responsibility to obtain my informed consent when required for any care and/or treatment provided by or at the Facility under the general or special instructions of my treating physician/surgeon.
3. **NO LEGAL RELATIONSHIP BETWEEN FACILITY AND PROVIDERS**. I recognize that most physicians and independent contractors providing services to me, including, but not limited to, my treating physician/surgeon, radiologists, pathologists, cardiologists, emergency physicians, anesthesiologists, staff physicians, contract physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, perfusionists, and others who may provide care and/or treatment to me during my Facility visit (individually each, and collectively all, the "**Provider(s)**"), are not employees or agents of the Facility. The Providers have been granted the use of the Facility for the care and treatment of their patients, but they may not be employees or agents of the Facility.
4. **DELEGATION OF PHYSICIAN AND OTHER CARE**. The Facility delegates to Providers the provision of care and treatment to patients of the Facility, and the Facility is not legally or vicariously responsible for the conduct, decisions, or actions of the Providers providing care in the Facility.
5. **CONTROL OF MEDICAL DECISIONS**. The Facility does not control the medical decisions, diagnosis, or treatments rendered by the Providers treating me in the Facility.
6. **UTILIZATION OF OTHERS IN MY CARE.** Under the direction of my treating physician/surgeon, physician assistants, advanced registered nurse practitioners, students and physicians in training may be utilized in my care and treatment.
7. **NURSING CARE**. This Facility provides only general nursing care and care ordered by my treating physician/surgeon. If I want a private duty nurse or sitter, I agree to make such arrangements, including financial. The Facility is not responsible for failure to provide a private duty nurse or sitter, and is hereby released from any and all liability arising from the fact that the Facility does not provide this additional care.
8. **CONSENT TO TRANSFER TO ALTERNATE FACILITY.** I hereby consent to be transferred to another facility for further medical treatment if my medical condition indicates that transfer is appropriate in the judgment of my treating physician/surgeon, and such transfer is made in accordance with applicable laws and regulations governing Facility transfers.
9. **CONSENT TO PHOTOGRAPH.** I understand that photographs, video, or other images may be taken to document my care, for patient identification, and/or as part of the education process for residents and nurses.
10. **CONTRABAND/WEAPONS/DRUGS.** I agree that should the Facility find contraband, weapons, and/or drugs which are not prescribed for me (or are not sold over the counter) within my possession, the Facility may take corrective action to correct the issue, including, but not limited to, confiscating the items, calling the police, etc.
11. **RELEASE FROM LIABILITY FOR VALUABLES.** As a patient, I am encouraged to leave personal items at home. I have been made aware that the Facility provides a safe for the safekeeping of valuables small enough to fit in a security envelope. I therefore release Facility from any liability due to loss or damage to any valuables unless deposited with Facility for safekeeping. Facility shall not in any event be liable to me for any loss of, or damage to, any personal property in excess of $100.00. Unclaimed valuables will be disposed of in accordance with Florida law and the Facility valuables policy.
12. **RECEIPT OF PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES BROCHURE AND NOTICE OF PRIVACY PRACTICES.** By my signature on this document, I acknowledge that I received, prior to or at the time of admission, a Patient's Bill of Rights and Responsibilities brochure and a Notice of Privacy Practices.
13. **TOBACCO FREE ENVIRONMENT.** The Facility prohibits the use of tobacco products anywhere within the Facility or its campus. If I choose to engage in this prohibited activity, I understand I am removing myself from the Facility's care and may be discharged from the Facility. I will assume all risks associated with this prohibited activity, which may include medical complications, injury, and/or death. I hereby release the Facility from any and all liability associated with this prohibited activity.
14. **RELEASING MEDICAL INFORMATION.** I understand that the Facility, its business associates, any treating physician/surgeon, and/or my insurance company may obtain, use and/or disclose information for the purposes of treatment, payment, and normal healthcare operations. This use and disclosure may include collection agencies and credit bureaus. Information may include psychiatric, drug abuse, alcohol, and/or HIV status. I understand that if I do not consent to release of information for payment purposes, the Facility and other health care providers will be unable to bill my insurance company or other party which is or may be responsible for payment for the services documented by the withheld information, and I will be billed directly for these services. Patients with implantable devices consent to the release of their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of

PATIENT

CONDITIONS OF ADMISSION AND TREATMENT

uses and disclosures for treatment, payment or normal healthcare operations, please review the Facility's Notice of Privacy Practices referenced in Section 12 above.

15. **EXTERNAL PRESCRIPTION HISTORY**. As part of my care and treatment, I hereby consent to allow Facility and/or Providers to access and obtain external medication and prescription history information from retail pharmacies and pharmacy benefits managers (e.g., SureScripts, RxHub, etc.).
16. **MEDICARE/MEDIGAP/MEDICAID PATIENT CERTIFICATION/RELEASE OF INFORMATION AND PAYMENT REQUEST.** I certify that the information given by me to apply for payment under Title XVIII and/or Title XIX of the Social Security Act is correct. I also certify that I have complied, and will continue to comply, with all laws applicable to any such payments, including any obligation to protect the interests of the payors of any such payments as may be required or necessary. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers any information related to any Medicare, Medigap, or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for Facility or Provider services to the Facility or Provider furnishing the services (as applicable), or I authorize such Facility or Provider to submit a claim to Medicare, Medigap, or Medicaid for payment. I understand that I am responsible for any health insurance deductibles, co-insurance, co-payments, and all non-covered charges.
17. **ASSIGNMENT OF INSURANCE AND OTHER BENEFITS.** I hereby assign to Facility and/or the Provider (as applicable), all of my rights and interests to any and all benefits or other recovery of any type whatsoever receivable by me or on my behalf arising out of any policy of insurance insuring me (or any other third party responsible to me) for the costs incurred in receiving services from the Facility and/or Provider (as applicable), including, but not limited to: any private or group health/hospitalization plan, automobile liability, general liability, personal injury protection, medical payments, uninsured or underinsured motor vehicle benefits, settlements/judgments/verdicts, or any other third-party payor. I authorize direct payment to Facility and/or the Provider (as applicable) of all such benefits or recovery. I hereby authorize and designate the Facility and/or the Provider (as applicable) as my authorized representative for purposes of the appeal of any claim under this assignment. I hereby authorize and designate Facility and/or the Provider (as applicable) as my authorized representative to act on my behalf with respect to all matters related to the appeal of my claim, including, but not limited to, receiving all information, documentation, and/or notifications related to my claim. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law.
18. **PATHOLOGISTS' CHARGES.** I understand that testing of my laboratory specimens is performed under the supervision of the pathologists that direct the laboratory. Although they may not personally perform the test or review the results, the pathologists are responsible for supervising the laboratory and reporting my tests to my treating physician/surgeon. I understand that I will receive a bill from the pathologists for these supervisory services. By signing below, whether I sign as patient or patient's agent/representative, I agree to pay the pathologists' bill for supervisory services to the extent that it is not paid by an insurance or managed care plan.
19. **GUARANTEE OF PAYMENT.** I agree to unconditionally guarantee and promise to pay the Facility and/or the Provider (as applicable), all charges incurred in my care and treatment in accordance with the regular rates and terms of the Facility and/or the Provider (as applicable), or such other rates and terms as are applicable to my account(s) by contract, policy, or regulation. Such charges include, but are not limited to: any deductibles, co-insurance, co-payments, and non-covered charges. All charges shall be paid in accordance with Facility and/or Provider (as applicable) policy and/or processes, but no later than presentation of the first bill by the Facility and/or Provider (as applicable). I agree that if Facility and/or the Provider (as applicable) have been unable to verify my coverage, or to secure authorization of responsible third party payor(s), I will pay the entire estimated charge(s) upon presentation of the first bill by the Facility and/or Provider (as applicable). I understand that Facility and/or Provider (as applicable) shall be entitled to charge interest on all unpaid accounts at the maximum rate provided by Florida law. Any payments received from me, or on my behalf, shall first be applied to any interest, penalties, and outstanding balance(s). I understand and agree that if Facility and/or the Provider (as applicable) are required to bring a claim or file an action to enforce this agreement and/or recover any charges, the Facility and/or the Provider (as applicable) shall be entitled to recover its reasonable attorneys' fees and any other costs of collection. The undersigned waives any exemptions from garnishment, attachment, or legal process in favor of Facility and/or Provider (as applicable) to the extent permitted by federal or state law.
20. **FINANCIAL INFORMATION**. I acknowledge that during the course of my admission and after discharge, I may be asked to provide financial information for the purposes of determining eligibility for uncompensated care, applying for government programs, instituting payment arrangements, or for other related purposes. I hereby certify that any such information provided by me will be provided in good faith and will be accurate to the best of my knowledge. I hereby authorize Facility to obtain credit reports concerning me from one or more credit bureaus. I understand Facility may obtain credit reports concerning me without my written authorization under some circumstances, as permitted by law. I hereby authorize Facility to provide information about me (whether received from me or from a credit bureau) to third parties for business-related purposes, including, but not limited to: billing, collection, instituting payment arrangements, and determining eligibility for uncompensated care and/or government programs.
21. **FACILITY CHARGES.** You have the right to receive an itemized bill upon request. The Facility reserves the right to change the rates it charges at any time. The amount of the patient's Facility charges may differ from the amounts that other patients are obligated to pay based upon each patient's insurance coverage, Medicare/Medicaid coverage, or lack of any such coverage.
22. **AUTOMATED COMMUNICATION.** I authorize the Facility and/or business associates of the Facility to contact me via telephone, cellular phone, and/or electronic mail using pre-recorded

PATIENT

CONDITIONS OF ADMISSION AND TREATMENT

messages, auto-dialers, and/or other forms of automated/electronic communication. Electronic mail communication can be intercepted in transmission or misdirected. Your use of electronic mail communication to us indicates that you acknowledge and accept the possible risks associated with such communication.

23. **FACILITY DIRECTORY.** ☐ If box is checked, I DO NOT want to be listed in the Facility directory. I understand the Facility will not direct visitors/callers to me when they ask for me by name. I understand clergy will not be given my information to visit me unless specifically consulted, and special deliveries will be sent back to the vendor.

IF INITIALED HERE _____ (INITIALS), THIS AGREEMENT WILL REMAIN IN EFFECT AND APPLY TO ANY AND ALL OF MY ADMISSIONS AT ANY AND ALL FACILITIES UNTIL REVOKED BY ME IN WRITING TO: BAYCARE CENTRAL BUSINESS OFFICE, ATTENTION: MANAGEMENT SUPPORT, 3986 TAMPA ROAD, OLDSMAR, FL 34677. I UNDERSTAND THAT I MAY OCCASIONALLY BE ASKED TO UPDATE THE INFORMATION PROVIDED IN CONNECTION WITH THIS AGREEMENT OR TO SIGN A NEW AGREEMENT.

I HEREBY AGREE THAT THE TERMS OF THIS AGREEMENT HAVE BEEN COMPLETELY READ, FULLY UNDERSTOOD, AND THAT I MAY OBTAIN A COPY OF THIS AGREEMENT UPON REQUEST. I CERTIFY THAT I AM THE PATIENT, OR THAT I AM DULY AUTHORIZED TO ACT AS THE PATIENT'S AGENT OR REPRESENTATIVE, AND I HEREBY VOLUNTARITY ACCEPT ALL THE TERMS AND CONDITIONS OF THIS AGREEMENT.

Patient Signature	Date	Patient's Date of Birth

Patient unable to sign because:

Signature of Patient's Authorized Representative	Relationship to Patient	
Signature of Facility Representative (Witness)	Team member #	Date

PATIENT