Boca Raton Regional Hospital
BAPTIST HEALTH SOUTH FLORIDA

GENERAL CONSENT FOR TREATMENT

General Consent for Medical Treatment: I hereby authorize the above named physician, ER physician or any physician or other care providers designated by him/her, providing care to the above named patient to render such care including diagnostic procedures, physical and mental examinations, medical treatment, and medications as they may deem to be necessary or advisable in the diagnosis or treatment of this patient ("Treatments") and I direct Boca Raton Regional Hospital, Inc. ("Hospital"), its employees, and authorized agents to follow his/her or their instructions and direction. In the event, the above named patient is receiving ongoing Treatments for the same diagnosis or medical condition, I authorize this consent to serve as the consent for the duration of the Treatment unless otherwise revoked and understand that I have a duty to inform my physician of any changes to my condition. I understand that the Hospital provides nursing care as required by the condition of the patient and should the patient or undersigned desire additional private duty nursing care (one-to-one nursing, sitter services, or nurse assistant coverage), the Hospital may provide contact information for area agencies who could provide this service at the patient's expense. I further understand that the Hospital respects the rights of self-determination and that I have the right to make informed decisions regarding all care and Treatments including the right to refuse any Treatments I do not want and should ask my health care professional to clarify or explain anything I do not understand. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to results of Treatments, tests or examination in the Hospital.

Guarantee of Payment: In consideration for the services to be provided to the patient, each of the undersigned promise(s) to pay the Hospital and any physician providing services during the period of this encounter or admission, all amounts legally due and not paid by Medicare, a third party payor, or other source on my behalf for services so rendered, which payment shall be due in full at the time of discharge. I understand that Treatment performed by physicians will be billed separately from the Hospital. I understand that I may apply for financial assistance in accordance with the Hospital's Charity Care Policy. In the event it is necessary to refer this account to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection, including reasonable attorney fees. I authorize the Hospital or business associates of the Hospital to contact me by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, or contact me via telephone, cell telephone, or electronic mail owned or used by the patient or responsible party for debt collection purposes. I hereby authorize the Hospital and its assignees to order a consumer credit report and verify other credit information.

Assignment of Benefits: In consideration for the services rendered or to be rendered, I hereby irrevocably assign and transfer to the Hospital, and to any physician providing services, all rights, title and interest, to the benefits payable by any and all third party payors (including Medicare and Medicaid) that are available or may be liable for the services rendered to the patient. If I am eligible for any Medicare or Medicaid benefits, I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is true and correct and I authorize the release of any information about me to any government contractors as needed for this or related to this claim. I further assign the proceeds of any settlements, judgments or verdict from third party liability claims for injuries treated by the Hospital to the Hospital and its treating providers in an amount equal to the outstanding balance of all charges due and owing. This irrevocable assignment and transfer shall allow the Hospital, or those physicians, to pursue any such right of recovery. Even though I have made this assignment, I understand the Hospital has the right to demand payment in full from me and the liability shall remain joint and several as between myself and all guarantors and third party payors, and I am responsible for payment for any charges not paid for me on my behalf.

Legal Relationship Between Hospital, Physicians and Other Allied Health Professionals: I understand and agree that most physicians performing services in the Hospital including consulting physicians, physicians on call, and Hospital-based physicians (e.g. Emergency Department, Radiology, Pathology, Anesthesiologists, Hospitalists, Neonatologists, Obstetricians, Gynecologists, Residents, and any other House-based Physicians) as well as certain physician assistants, certified nurse midwives, advanced nurse practitioners, and nurse anesthetists are independent contractors and not employees or agents of the Hospital even if they wear a Hospital issued security badge, and the Hospital is not liable for their actions or inactions. I further understand and agree that the Hospital may delegate the performance of duties to independent contractors as referenced above and that I hereby expressly discharge the Hospital of any such duty or liability so delegated. I acknowledge that such providers may not be contracted with my insurance plan which may result in additional out of pocket expenses.

Facility, Related Party & Third Party Communications; Email Communications: I hereby consent to and authorize Baptist Health affiliated entities as well as any third parties acting on their behalf or for their benefit and any successors, assigns, affiliates, medical staff, employees, officers, directors and/or agents, including without limitation any of their debt collectors and/or marketers, (collectively, the "Consented-To Parties"), to make calls to, send text messages to, send facsimile machine messages and/or advertisements to, send e-mail messages or advertisements to or otherwise communicate with me and/or contact me at any telephone number, facsimile machine number or e-mail address associated with my account(s), including, without limitation, any facsimile machine number, e-mail address, telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which I am charged for the call, whether such number or e-mail address was provided by me in the past, present or future or whether such number or e-mail address was obtained by any other method whatsoever. I agree that methods of contact may include but shall not be limited to using pre-recorded or artificial voice message and/or an automatic telephone dialing system or any other telephonic, computerized or technologically enhanced equipment or devices to enable such communications as set forth above.

By providing an e-mail address above, I will be able to access the BRRH patient portal to obtain information about the services I received at the Baptist BRRH affiliated entities. I consent to the use of that e-mail by the Consented-To-Parties to communicate with me and to send me information, collection notices and advertisements whether related to the services provided by the Consented-To-Parties, and for all other related reasons. However, e-mail will not be used to communicate clinical information about my condition, care, or treatment with me unless I separately consent to use e-mail for that purpose. I understand that Consented-To-Parties and their employees, medical

staff and agents may use, save, and have access to e-mails that are sent from or to me for these and any legally permitted purposes. I also understand that e-mails may include personal information about me, that information included may be accessed by any individual who has access to the e-mail address I have provided, and that it is my responsibility to safeguard access to that information. (Note: Any e-mail addresses provided by a parent for communication on behalf of a patient who is their minor child will no longer be used by Baptist Health after the date that child becomes an adult).

This consent and authorization shall be construed as broadly as possible under any and all applicable state and federal laws including, without limitation, 47 U.S.C. § 227. I further acknowledge, declare and state that the foregoing consent and authorization is intended to be and shall be construed to be effective retrospectively, *nunc pro tunc*, to the date of any and all covered communication(s) and shall continue until withdrawn by me in writing (or withdrawn by me in any other means that is expressly permitted by applicable federal or state law).

Acknowledgements: I acknowledge receipt of information regarding patient rights, the Hospital's Notice of Privacy Practices, information regarding advance directives (as applicable), and appropriate Medicare notices (as applicable). I acknowledge that should I be admitted, I have the right to request that my treating physician consult with my primary care provider or specialist provider, if any, when developing my plan of care. If choosing to execute this right, my request must be verbally expressed to my treating physician. I understand and agree that: 1) the Hospital is a teaching Hospital and that medical students, Residents, and other observers may participate in, or may be present during, my Treatments; 2) based on my medical condition, my care provider may take photographs, video or otherwise capture images that may be used only for the purposes of medical care, education, performance improvement, de-identified research, and such other purposes permitted by law; 3) the Hospital does not accept any responsibility for money, jewelry, dentures, eyeglasses, hearing aids, electronic devices, or any other valuables or belongings brought to the Hospital and that jewelry cannot be worn during operative procedures and patients must leave all valuables at home or with a relative.

I agree and acknowledge that I have received, viewed, read, understand, and accept the terms of this consent in its entirety. To the extent that I did not understand any provision. I acknowledge that the Hospital provided me with the opportunity to ask questions and that the Hospital answered my questions to my satisfaction.

Signature of Patient / Personal Representative	Date	Time	Print Name and Relationship to Patient if signed by Personal Representative

For Office Use Only *Office Representative:* _____

Patient Signature/Acknowledgement of Receipt of Notice of Privacy Practices or Other Information not obtained because:

☐ Patient/Patient Representative declined or unable/unwilling to acknowledge receipt ☐ Language barrier

☐ Emergency situation ☐ Other _____

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