PATIENT AGREEMENT AND CONSENT FOR SERVICES

As a condition of, and in consideration of, my and/or my guardian's/child's (collectively, "**I**" or "**me**") admission and treatment to any health care facility owned, operated, and/or affiliated with BayCare Health System, Inc., including, without limitation, Bartow Regional Medical Center, BayCare Alliant Hospital, BayCare Behavioral Health, BayCare Laboratories, BayCare Outpatient Imaging, BayCare Outreach Laboratory Services, Behavioral Health Management Services, Mease Countryside Hospital, Mease Dunedin Hospital, Morton Plant Hospital, Morton Plant Mease Health Care, Morton Plant North Bay Hospital, South Florida Baptist Hospital, St. Anthony's Hospital, St. Joseph's Children's Hospital, St. Joseph's Health Care Center, St. Joseph's Hospital, St. Joseph's Hospital – North, St. Joseph's Hospital – South, St. Joseph's Women's Hospital, Winter Haven Hospital, and/or Winter Haven Women's Hospital (individually each, and collectively all, the "**Facility**"), and/or as a condition of, and in consideration of, my treatment with BayCare Medical Group, BayCare Behavioral Health Associates, BayCare Urgent Care, and/or their respective offices (individually each, and collectively all, the "**Physician Organization**"), I hereby agree to the following:

1. **CONSENT FOR SERVICES.** I consent to the care, procedure, service and/or treatment provided at the Facility and/or Physician Organization. This may include, but is not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, the provision of 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, procedure, service, and/or treatment may involve serious risks, including but not limited to, severe injury or death. I acknowledge that no guarantees have been made regarding the result of any care, procedure, service, and/or treatment.
2. **INFORMATION AND INFORMED CONSENT.** I will look solely to my treating physician/surgeon for any questions or answers regarding my care, procedure, service, and/or treatment, and it is my treating physician/surgeon's sole responsibility to obtain my informed consent when required for any care, procedure, service, and/or treatment provided at the Facility or at the respective offices of the Physician Organization. I understand that it is not the duty or obligation of the Facility or Physician Organization to provide me with informed consent for a procedure, service, or treatment. Rather, it is the sole obligation or duty of my treating physician/surgeon to provide informed consent and not the obligation or duty of the Facility or the Physician Organization. If I am receiving any care, procedure, service, and/or treatment from a Provider (as hereinafter defined) who is employed by a Physician Organization, I acknowledge, agree, and confirm that my treating physician and/or advanced care practitioner has provided me with a general understanding of the proposed care, procedure, service, and/or treatment, the medically accepted alternative care, procedures, services, and/or treatments, and the substantial risks and hazards inherent in the proposed care, procedure, service, and/or treatment, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or other health care providers and their advanced care practitioners in the same or similar community who perform similar care, procedures, services, and/or treatments. I expressly release and discharge the Facility and/or Physician Organization from any and all liability arising from any alleged failure to provide me with informed consent for any care, procedure, service, and/or treatment.
3. **NO LEGAL RELATIONSHIP BETWEEN FACILITY AND PROVIDERS.** I hereby acknowledge and agree that the physicians and advanced care practitioners providing any care, procedure, service, and/or treatment to me, including, but not limited to, my treating physician/surgeon, radiologists, pathologists, cardiologists, emergency physicians, anesthesiologists, specialists, staff physicians, contract physicians, physician assistants, advanced practice registered nurse, certified nurse midwives, perfusionists, physician extenders, and others who may provide services to me (individually each, and collectively all, the "**Provider**"), are not employees or agents of the Facility. Likewise, I acknowledge and agree that if I am receiving services from a Provider who is employed by a Physician Organization, the Provider is not an employee or agent of the Facility and is instead solely an employee or agent of the Physician Organization. By signing below, I expressly release and discharge any and all claims of vicarious liability against the Facility based upon or arising out of the actions or inactions of Providers during my care, procedure, service, and/or treatment.
4. **NO JOINT VENTURE, PARTNERSHIP, AGENCY, OR SIMILAR RELATIONSHIP.** I understand and acknowledge that this Patient Agreement and Consent for Services does not create a joint venture, partnership, agency, or other similar relationship among the Facility, Physician Organization, and/or Provider. I understand that the Facility, Physician Organization, and Provider act independently of each other, and I expressly release, waive, and discharge any and all claims against the Facility, Physician Organization, and/or Provider for liability arising under claims of joint venture, partnership, agency, or other similar relationship.
5. **DISCHARGE OF LIABILITY.** I hereby acknowledge and agree that this Patient Agreement and Consent for Services is not an agreement for the Facility or Physician Organization to perform any care, procedure, service, and/or treatment. All care, procedures, services, and/or treatments will be performed by Providers who are not employees or agents of the Facility. To the extent any duty to perform any care, procedure, service, and/or treatment is imposed upon the Facility, the responsibility for performance of such care, procedure, service, and/or treatment is delegated to the Providers. The Facility is in no way responsible for, and I hereby release and discharge the Facility from, the conduct, decisions, and/or actions of the Providers providing any care, procedure, service, and/or treatment.
6. **CONTROL OF MEDICAL DECISIONS.** I understand that the Facility does not control the medical decisions, diagnosis, or treatments rendered by the Providers.
7. **UTILIZATION OF OTHERS IN MY CARE.** Under the direction of my treating physician/surgeon and/or advanced care practitioner, I acknowledge and agree that students, residents, or fellows may be utilized in my care, procedure, service, and/or treatment. In addition, I acknowledge and agree that I may receive medical care in a Facility or Physician Organization from a Provider, student, resident, and/or fellow who is employed by or is an agent of a university or other public institution (individually each, and collectively all, the "**Education Program**"), and that any liability that may arise from such Provider, student, resident, or fellow will be limited as provided by law.
8. **NURSING CARE.** The Facility provides only general nursing care to its patients. 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 such additional care.

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9. CONSENT TO TRANSFER TO ALTERNATE FACILITY. I hereby consent to be transferred to another facility for further care, procedures, services, and/or treatments if my medical condition indicates that transfer is appropriate in the judgment of my treating physician/surgeon.

10. IMAGES, RECORDINGS, AND ELECTRONIC TRANSMISSIONS. I hereby acknowledge and agree that photographs, videos, audio recordings, palm scans, and/or other images, recordings, and/or electronic transmissions may be taken to document my care, procedure, service, and/or treatment, for patient identification, for patient safety, for security, and/or to support the education and/or monitor the quality of care of the Providers, students, residents, and/or fellows. I further acknowledge and agree that I will not take photographs, videos, audio recordings, and/or other images, recordings, and/or electronic transmissions within the Facility or Physician Organization without the prior written approval of the Facility or Physician Organization.

11. CONTRABAND/WEAPONS. I agree that I will not bring any contraband (including, without limitation, alcohol, illicit/street drugs or drug paraphernalia, unmarked or unidentified powders or liquids, unapproved prescription drugs, unapproved over the counter medications, and unapproved herbal remedies) or weapons (including, without limitation, dirks, knives, metallic knuckles, slungshots, billies, tear gas guns, chemical weapons or devices, firearms, and other deadly weapons) to a Facility or Physician Organization site. I acknowledge and agree that the Facilities and/or Physician Organizations may conduct searches and/or require me to pass through metal detection devices when I am at their sites, and I acknowledge and agree that if the Facilities and/or Physician Organizations find contraband and/or weapons in my possession when I am at their sites, the Facilities and/or Physician Organizations may take corrective action, including, but not limited to, confiscating the items or calling law enforcement. I hereby release the Facilities and Physician Organizations from any liability related to such searches, metal detection activities, and/or any loss or damage of any items pursuant to this Section.

12. RELEASE FROM LIABILITY FOR VALUABLES. I acknowledge and agree that patients are encouraged to leave personal items at home. I, however, also understand that the Facility provides a repository for the safekeeping of valuables small enough to fit in an envelope. I hereby release the Facility from any liability due to loss of, or damage to, any of my valuables or personal items that are placed within the repository at a Facility. I further acknowledge and agree that in no event shall the Facility be liable to me for any loss of, or damage to, any of my valuables or personal property in excess of $100.00. Unclaimed valuables will be disposed of in accordance with Florida law and the Facility's policies.

13. RECEIPT OF PATIENT RIGHTS AND RESPONSIBILITIES AND HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") NOTICE OF PRIVACY PRACTICES. By signing below, I acknowledge that prior to, or at the time of, my admission or my care, procedure, service, and/or treatment, I received a written and conspicuous copy of the Patient Rights and Responsibilities document and the HIPAA Notice of Privacy Practices.

14. SMOKE FREE ENVIRONMENT. The Facility and Physician Organization prohibit the use of tobacco products and electronic cigarettes at the Facility and Physician Organization. If I choose to engage in this prohibited activity, I understand that I am removing myself from the Facility's and the Physician Organization's care and may be discharged from the Facility, the Physician Organization, and/or my individual Provider. I will assume all risks associated with this prohibited activity, which may include medical complications, injury, and/or death. I hereby release the Facility, Physician Organization, and/or Provider from any and all liability associated with this prohibited activity.

15. RELEASE OF PROTECTED HEALTH INFORMATION. I understand that the Facility, Physician Organization, any treating Provider, my insurance company, and/or their business associates may obtain, use, and/or disclose protected health information about me for the purposes of treatment, payment, and/or 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 the release of information for payment purposes, the Facility, Physician Organization, and Providers will be unable to bill my insurance company or another party that is, or may be, responsible for payment for the services documented by the withheld information, and I will be billed directly for such services. Patients with implantable devices specifically consent to release their Social Security numbers to the device manufacturer to comply with the Safe Medical Devices Act. For a more detailed description of uses and disclosures for treatment, payment, or normal healthcare operations, please review the HIPAA Notice of Privacy Practices referenced in Section 13 above.

16. EXTERNAL PRESCRIPTION HISTORY. As part of my care, procedure, service, and/or treatment, I hereby consent to allow the Facility, Physician Organization, 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.).

17. 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 its 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 the Facility, Physician Organization, and/or Provider services to the Facility, Physician Organization, or Provider furnishing the services, and I authorize such Facility, Physician Organization, 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 noncovered charges.

18. ASSIGNMENT OF BENEFITS. I hereby assign to the Facility, Physician Organization, and/or the Provider, all of my rights, benefits, privileges, protections, claims, causes of action, interests, or recovery, to any and all rights, benefits, privileges, protections, claims, causes of action, interests, or recovery of any type whatsoever receivable by me or on my behalf arising out of any policy of insurance, plan, trust, fund, or coverage providing health care coverage of any type to me (or to any other third party responsible for me) for the charges for services rendered to me from the Facility, Physician Organization, and/or Provider. This includes, without limitation, 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, self-funded plan, trust, MEWA, collective, or any other third-party payor (collectively, the "**Coverage Source**"). I authorize direct payment to the Facility, Physician Organization, and/or the Provider of all benefits, payments, monies, checks, funds, wire transfers, or recovery of any kind whatsoever. I agree that any payments of any kind (e.g., checks, funds, payments, monies, benefits, or recovery) for coverage of services by the Facility, Physician Organization, and/or Provider that are sent directly to me (or to another third party responsible for me) will be sent immediately to the Facility, Physician Organization, and/or Provider through whatever means necessary. This includes, without limitation, endorsing over any checks and/or other documents to the Facility, Physician Organization, and/or Provider. I agree to assist the Facility, Physician Organization, and/or Provider in pursuing payment from any Coverage Source. This includes, without limitation, signing documents requested or needed to pursue claims and appeals, get documents from Coverage Source, or otherwise to support payment to the Facility, Physician Organization, and/or Provider. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law.

19. **AUTHORIZED REPRESENTATIVE.** I hereby authorize and designate the Facility, Physician Organization, and/or the Provider as my authorized representative to act on my behalf with respect to all matters related to all of my rights, benefits, privileges, protections, claims, causes of action, interests, or recovery arising out of any policy of insurance, plan, trust, fund, or coverage providing health care coverage of any type to me (or to any other third party responsible for me). This includes, without limitation, filing claims and appeals, receiving all information, documentation, summary plan descriptions, bargaining agreements, trust agreements, contracts, and other instruments under which the plan is established or operated, as well as receiving any policies, procedures, rules, guidelines, protocols, or other criteria considered by the Coverage Source, in connection with any claims, appeals, or notifications related to claims or appeals.
20. **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/advanced care practitioner. I understand that I will receive a bill from the pathologists for these supervisory services. By signing below, whether I sign as the patient or the 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.
21. **GUARANTEE OF PAYMENT.** I agree to unconditionally guarantee and promise to pay the Facility, Physician Organization, and/or Provider, all charges incurred in my care, procedure, service, and/or treatment in accordance with the regular rates and terms of the Facility, Physician Organization, and/or Provider, 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 the policies and/or processes of the Facility, Physician Organization, and/or Provider, but in no event later than presentation of the first bill by the Facility, Physician Organization, and/or Provider. I agree that if the Facility, Physician Organization, and/or Provider 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, Physician Organization, and/or Provider. I understand that the Facility, Physician Organization, and/or Provider 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). In the event that there is a credit balance on my account with a Facility or Physician Organization, I acknowledge and agree that such credit balance may be applied to other bills that I owe to other Facilities and/or Physician Organizations. I understand and agree that if the Facility, Physician Organization, and/or Provider are required to bring a claim or file an action to enforce this agreement and/or recover any charges, the Facility, Physician Organization, and/or Provider shall be entitled to recover reasonable attorneys' fees and any other costs of collection. The undersigned waives any exemptions from garnishment, attachment, or legal process in favor of the Facility, Physician Organization, and/or Provider to the extent permitted by federal or state law. I hereby expressly consent to allow the Facility, Physician Organization, and/or Provider (and/or business associates/third party collection agencies of the Facility, Physician Organization, and/or Provider) to contact me (including, but not limited to, through use of contact information and/or telephone numbers that I have provided to the Facility, Physician Organization, and/or Provider) for debt collection and/or payment purposes.
22. **FINANCIAL INFORMATION.** I acknowledge that during and after the course of my care, procedure, service, and/or treatment, 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 the Facility, Physician Organization, and/or Provider (and/or business associates/third party collection agencies of the Facility, Physician Organization, and/or Provider) to obtain credit reports and other data concerning me from one or more credit bureaus. I understand that the Facility, Physician Organization, and/or Provider (and/or business associates/third party collection agencies of the Facility, Physician Organization, and/or Provider) may obtain credit reports and other data concerning me without my written authorization under certain circumstances, as permitted by law. I hereby authorize the Facility, Physician Organization, and/or Provider 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.
23. **FACILITY CHARGES.** You have the right to receive an itemized bill upon request. The Facility, Physician Organization, and/or Provider reserves the right to change its rates at any time. The amount you are obligated to pay 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.
24. **AUTOMATED AND NON-AUTOMATED PATIENT COMMUNICATION.** I hereby expressly consent to allow the Facility, Physician Organization, and/or Provider (and/or business associates/third party collection agencies of the Facility, Physician Organization, and/or Provider) to contact me (including, but not limited to, through the use of contact information and/or telephone numbers that I have provided to the Facility, Physician Organization, and/or Provider) via telephone, text message, cellular phone, electronic

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

25. **SEVERABILITY.** If any provision, paragraph, or part of any paragraph of this Patient Agreement and Consent for Services is declared to be unlawful, invalid, or unenforceable for any reason, the remaining terms, provisions, paragraphs, or sections shall remain in full force and effect.

I EXPRESSLY ACKNOWLEDGE AND AGREE THAT THIS AGREEMENT CONSTITUTES THE SOLE AND ENTIRE AGREEMENT WITH RESPECT TO THE SUBJECT MATTER OF THIS AGREEMENT, AND I EXPRESSLY ACKNOWLEDGE AND AGREE THAT THIS AGREEMENT SUPERSEDES ALL PRIOR AND CONTEMPORANEOUS UNDERSTANDINGS, AGREEMENTS, REPRESENTATIONS AND WARRANTIES, BOTH WRITTEN AND ORAL, WITH RESPECT TO THIS SUBJECT MATTER. I EXPRESSLY ACKNOWLEDGE AND AGREE THAT I HAVE NOT RELIED ON ANY STATEMENT, REPRESENTATION, WARRANTY OR AGREEMENT OF THE FACILITY, PROVIDERS, OR OF ANY OTHER PERSON ON SUCH PARTY'S BEHALF, INCLUDING ANY REPRESENTATIONS, WARRANTIES, OR AGREEMENTS ARISING FROM STATUTE OR OTHERWISE IN LAW, EXCEPT FOR THE TERMS EXPRESSLY CONTAINED IN THIS AGREEMENT.

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, 2995 DREW STREET, MAILSTATION #1045, CLEARWATER, FL 33759. 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 THE PATIENT HAS EXPRESSLY AUTHORIZED ME TO SIGN AND CONSENT ON HIS/HER BEHALF, AND I HEREBY VOLUNTARILY ACCEPT ALL THE TERMS AND CONDITIONS OF THIS AGREEMENT. THIS DOCUMENT STANDS AS IS AND WITHOUT REVISIONS.

Patient Signature	Date	Time	Patient's Date of Birth

Patient unable to sign because: _____

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