BATES COUNTY MEMORIAL HOSPITAL
General Consent and Agreement for Health Care Services

I, the undersigned patient or patient's authorized legal representative, hereby consent to admission to Bates County Memorial Hospital ("BCMH") for diagnostic tests, procedures, care and treatment. I am aware that the practice of medicine is not an exact science and acknowledge that no promise, guarantee or warranty has been made regarding the results of medical treatment or examination. I consent to and authorize the following:

Clinical Services

CONSENT FOR TREATMENT: I consent to inpatient hospitalization, outpatient services, diagnostic tests, and hospital procedures, therapy and other services that may be deemed necessary for my diagnosis and treatment to be performed or ordered by the attending medical staff member or his/her designees, assistants, and BCMH staff. I authorize BCMH to take photographs, or other images, of me or parts of my body to be used in medical evaluations or education. BCMH does not routinely test all patients for hepatitis or for the human immunodeficiency virus (HIV). However, in the event that my physician feels it is necessary or in the event that a health care worker, employee, or volunteer is exposed to my blood or other body fluids, my blood may be tested for hepatitis or HIV infection. If my blood test indicates infection, my physician will be notified.

CONSENT FOR TELEMEDICINE: Telemedicine involves the use of electronic communications to enable patients at one location to receive services from health care providers at another location. Health care providers involved in telemedicine may include primary care providers, specialists and/or subspecialists. Telemedicine services may include interpretation of medical images or diagnostic studies by an off-site provider or may involve real-time two way audio and video communication with a provider. I authorize the use of telemedicine (e.g. video/audio technology such as eICU, eHospitalist, eConsults and other eHealth/telemedicine services) to monitor, assess and interact with me while under the care of BCMH to be used in medical evaluations, education or research. I understand that other individuals may be present at my location or the location of the health care provider during the services to operate telemedicine equipment or perform the physical examination at the direction of the health care provider.

PATIENT RIGHTS: I acknowledge that I have been informed of my *Patient Bill of Rights* and I have received a written copy. As a recipient of Federal financial assistance, BCMH does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, and in staff and employee assignments to patients, whether carried out by BCMH directly or through a contractor or any other entity with which BCMH arranges to carry out its programs and activities.

ADVANCED DIRECTIVES: I understand that I have an opportunity to make known my wishes, in writing, regarding my healthcare and/or end of life decisions. BCMH will provide me with information about Advanced Directives.

OBSERVERS: I consent to the presence of observers in the event that I may have a procedure performed. Observers may include visiting nurses and physicians, product vendors and/or members of the hospital administrative staff. I understand my right to refuse the presence of observers.

STUDENTS: I acknowledge BCMH participates in the education of students in various health programs who may participate in my care. I understand my right to refuse student participation in my care.

GENERAL DUTY NURSING: I understand that BCMH provides general duty nursing care where nurses are called to the bedside of the patient by a signal system. If I am in such condition as to need continuous or special duty nursing care, it is agreed that arrangements for those services are to be made by me or my representative. BCMH is not liable for failure to provide additional nursing care.

Communications

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of the *Bates County Memorial Hospital Notice of Privacy Practices.*

COMMUNICATIONS ABOUT MY HEALTHCARE: I consent to the use and/or disclosure of my protected health information for purposes of treatment, payment, or healthcare operations and other purposes, as permitted by state and federal privacy law. I may request restrictions on the use of disclosure of my protected health information as described in the *Bates County Memorial Hospital Notice of Privacy Practices.* I authorize the disclosure of my protected health information for purposes of communicating results, findings, and care decisions to those individual whom I have given passcode access.

PATIENT PORTAL: I understand that I may receive an e-mail from BCMH inviting me to enroll in BCMH's online patient portal to provide the ability for me to securely communicate online with my physician.

PATIENT DIRECTORY: I agree to the inclusion of my name, location, condition, and religious affiliation in the patient directory. This information may be released to the clergy and those individuals who ask for me by name. I understand my right to refuse inclusion of my name in a patient directory.___Refusal (initial)

CONSENT TO MONITORING: As part of BCMH's patient care and monitoring system, I consent to the review of my medical records and to visits by members of the medical staff, hospital staff, and contracted staff during my stay at BCMH.

INTERPRETERS AND COMMUNICATION AIDS: I understand that it is my duty to inform my physician, nurse, or other hospital representative of any need for an interpreter or other method or device necessary to assist me in communicating. Such interpreters and communication aids are available to me free-of-charge.

PATIENT SATISFACTION SURVEY: BCMH may communicate with me regarding the care I received and use the information to improve the quality of care delivered at BCMH. I understand my right to refuse this communication.

Financial Responsibility

MEDICARE AND/OR MEDICAID: I certify that the information I provided in applying for payment under Title XVII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to BCMH, and authorize release of all patient records required to act on this request. (Consent applies only when applicable).

FINANCIAL RESPONSIBILITY: This certifies that I (or my guarantor) promise to pay my account at the rates established by BCMH for services provided. I understand that acceptance of insurance assignment by BCMH does not relieve me from my financial responsibility for my account.

ASSIGNMENT OF BENEFITS: In the event that I am entitled to hospital benefits of any type whatsoever arising out of any governmental or private insurance policy insuring me or any party liable to me, said benefits are hereby assigned directly to BCMH for application to my account. I understand that I am financially responsible to BCMH for the charges not paid under this assignment.

AUTHORIZATION TO FILE AN APPEAL: I understand that at times the level of care or medical necessity for services determined appropriate by my physician may differ from the opinion of my insurance company and the insurance company may deny payment of a portion of my BCMH billing. To assist me in resolving this dispute, I authorize BCMH or its billing agent to act on my behalf to file a grievance or appeal of such denial by my insurance company in accordance with applicable law and to also notify BCMH directly on the determination of such grievances or appeals.

PHONE AUTHORIZATION: Subject to any restriction or confidential communication that has been granted to me under BCMH's patient privacy policies, I grant permission to and consent to BCMH, or its assignees and third party collection agents, to (1) contact me by telephone at any telephone number I have provided, including wireless numbers; (2) leave answering machine and voicemail messages for me, and include in any such messages information required by law (including deb collection laws) and/or regarding amounts owed by me; (3) send me text messages or emails using any email addresses provided by me; and (4) use pre-recorded/artificial voice message and/or an automatic dialing device (an "autodialer") in connection with any communications made to me or related to my accounts.

FINANCIAL ASSISTANCE: I understand that BCMH has a financial assistance policy for which I may qualify. The income guidelines are based on Federal Poverty Limits. I understand that if I am a resident of Bates County and my income is less than the guideline for my family size, I may qualify for assistance. I have been offered the Financial Assistance Summary. ___Accepted ___Declined/Non-resident

INDEPENDENT CONTRACTORS: I understand that some medical staff members from whom I receive services at BCMH may not be employees of BCMH or may be independent contractors. The professional services rendered by these providers will be billed to me separately.

Responsibilities

TOBACCO FREE POLICY: I understand that BCMH and all Family Care Clinics are tobacco free. I acknowledge that I may not smoke or use any tobacco products anywhere on the campus, including the parking lot or grounds of the facility. If I make the decision to go off campus to smoke or use tobacco products, I take full responsibility for my own safety. I agree not to hold BCMH or any of its employees or agents responsible if I am injured in any way as a result of my decision to smoke or use tobacco products. State and Federal laws will be followed regarding smoking by minors. This tobacco free policy applies to e-cigarettes, vaping products and other alternative tobacco and nicotine products.

BEHAVIOR EXPECTATIONS: I agree that it is my responsibility to treat other patients, visitors and staff with respect and avoid offensive, threatening, and/or abusive language or behavior. I understand that such behavior could lead to evaluation for my discharge.

RELEASE OF RESPONSIBILITY FOR VALUABLES/PERSONAL PROPERTY: I understand that I am responsible for all valuables and personal belongings that I bring with me to BCMH. I release BCMH from all responsibility for the loss of or damage to money, valuables, or personal property (i.e. clothing, dentures, eyeglasses, hearing aids, walkers, as well as other medical devices) that are not placed in BCMH's safe.

By signing below, I acknowledge and agree that I have read and understand the above listed consents, agreements, authorizations, promises, certifications, understandings, releases and acknowledgements and I further acknowledge that I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me as the result of treatments or examinations while at BCMH.

Signature of Patient/Legal Representative: _____

Signature of Guarantor (other than custodial parent or legal guardian): _____

Witness: _____ **Date:**_____ **Time:**_____