Patient Name:_____

MRN:_____

Date of Birth:_____

ADVENTHEALTH TREATMENT AND CONSENT AGREEMENT

AdventHealth operates facilities including, but not limited to, hospitals, outpatient centers, medical groups, and Centra Care locations (referred to all together in this document as "AdventHealth") across many states. Many of these facilities are separate legal entities. You may ask us for a list of AdventHealth entities. This AdventHealth Treatment and Consent Agreement ("Agreement") may be signed one time each year to provide consent for treatment at all these AdventHealth facilities, unless you tell us you want to sign a new form at your appointment, or we update this form. This Agreement must be signed by the Patient or by the Patient's Legal Representative acting for the Patient (for example, a parent signing for their minor child). All references to "I", "me", "my", "you" and "your" refer to the Patient.

CONSENT TO TREATMENT:

1. Services. I consent to diagnostic and treatment procedures, examinations and laboratory procedures or inpatient admission or other items ("Services") needed for my treatment during my admission to or treatment at AdventHealth by doctors ("Physicians"), and other medical professionals, residents, students, integrated physician networks, health plan networks, and AdventHealth employees, contractors, and personnel (collectively "Care Providers"). I understand I will be told about my treatment and will be able to ask questions about the risks, options and hoped for outcome of the treatment before I let the treatment be done. I agree that no promises have been given to me as to the outcome of any treatment.

2. Photography. I consent to photographs, video or audio recordings being taken of me for verification of my identity and/or my treatment.

3. Independent Contractors. I understand that many of the Physicians and Care Providers who provide treatment to me at a hospital, ambulatory surgery center, free standing emergency department or urgent care facility are not employees or agents of AdventHealth. I understand that these independent contractors may, as permitted by law, bill me on their own for the Services they provide. Independent contractors are responsible for their own actions. AdventHealth is not responsible for Services provided to me by these independent contractors. AdventHealth does not pay for the errors or mistakes or failure to act by any of these independent contractors.

4. Patient Rights. I understand a copy of AdventHealth's Patient Rights and Responsibilities information will be offered to me as required by law.

5. Advance Directives. I have been able to tell AdventHealth about my current choices for Advance Directives by filling out a new form or giving them a copy of my earlier Advance Directives. AdventHealth, Physicians and Care Providers are not required to follow Advance Directives they do not know about. Please select which option(s) below applies to you:

☐ I am under 18 years of age and have no Advance Directives.

☐ I have Advance Directives and I have given a copy to AdventHealth.

☐ I have Advance Directives, but I have not given AdventHealth a copy. I understand I must give AdventHealth a copy.

☐ I do not have Advance Directives.

☐ I would like information about Advance Directives.

6. Legal Representative. I have been able to tell AdventHealth about my current choice for my Legal Representative by giving them a copy of my legal documents outlining my decision. AdventHealth, Physicians and Care Providers are not required to involve my Legal Representative in my treatment if they do not know who my Legal Representative is or if there are changes to this delegation they do not know about. I understand that I am responsible to tell AdventHealth, Physicians and Care Providers when I change my Legal Representative, or when the powers of the Legal Representative end.

7. Personal Property/Valuables. Where applicable, I will give any personal property or valuables to AdventHealth for storage in a secure location if I want to ensure my personal property and valuables are safe.

CONSENT TO PAYMENT:

1. Payment. I, or (where permitted by law) my Legal Representative signing this Agreement for me, must pay for the Services received during my treatment today and any related future Services provided by AdventHealth, Physicians and Care Providers ("Account"), including any required co-pays, with cash, check, credit card and/or insurance. I understand that no credit is being given to me and that the Account is due and payable right away. **If I cannot pay my Account in full when due, AdventHealth's Financial Services Office will determine if I qualify for any financial assistance.** If I do not pay for all my Services and AdventHealth sends my Account to an attorney or collection agency, I agree to pay the attorneys' fees and collection expenses as permitted by law up to 25% of the money I owe.

FOR ADVENTHEALTH FACILITIES IN COLORADO: I understand that if I am receiving treatment in Colorado, there are certain times when balance billing (when an out-of-network provider bills you for the difference between their billed charge and the amount your health insurance or plan pays) is prohibited. If a patient has or may have insurance, balance bills are prohibited under some state and federal laws when a patient receives:

- Emergency services;
- Non-emergency services from an out-of-network provider (like an anesthesiologist or radiologist) at an in-network facility, such as a hospital;
- Emergency services from a private ground ambulance provider (not from a fire department or government entity); and
- Services from an out-of-network air ambulance provider.

In these circumstances, some state and federal laws prohibit providers from sending me a surprise balance bill, and I cannot be charged for more than in-network cost-sharing for these services. I acknowledge I have received disclosures related to balance bills.

I also understand that in Colorado there is no guarantee of reimbursement or payment from any insurance company or other payer. I understand this Agreement is a contract and that it obligates me to pay all charges for my treatment not paid by my insurer or any other payer source, unless specifically prohibited by applicable law. I understand the hospital has pre-determined the charges for certain procedures, supplies, and treatments, which these charges are listed in the hospital's Chargemaster, and these prices are incorporated by reference into this Agreement. I acknowledge it may not be possible to state in advance which specific supplies and services will be part of my treatment. I acknowledge I have the right to request an estimate of the facility's average charge for treatments that are frequently performed on in-patient, outpatient, or surgical procedures. If I receive an estimate of charges, I acknowledge that the hospital is acting in good faith by providing such an estimate. I acknowledge that any estimate is not binding and that the charges I am personally obligated to pay may be more than the estimated charge for my specific treatment. I acknowledge this Agreement means I personally have full financial

responsibility for, and agree to pay, all charges of the hospital and of physicians rendering services not otherwise paid by my health insurance or other payer based upon the hospital's pre-determined Chargemaster rates, unless specifically prohibited by applicable law.

I hereby acknowledge and agree that the hospital has not made any implied representations about the charges I am personally obligated to pay. I understand the charges I will be charged for my treatment are pre-determined rates based upon the Chargemaster in effect at the time of my treatment. I have agreed to pay the hospital's Chargemaster rates for the treatment I receive in Colorado.

2. Credit Card Payments. If I pay for the Services with my credit card, I certify that I am the credit card holder and authorize payment of the Services.

3. Insurance Payments and Assignment of Benefits. If I am entitled to benefits under: (i) the Medicare program, the Medicaid program, other kinds of government insurance (the "Program"); (ii) Employee Retirement Income Security Act ("ERISA") health benefit plans; or (iii) any insurance policy or other health benefit plan (covering me or anyone legally responsible for me) or from any other source (the "Benefit Plan"), including as a result of injuries sustained by me, in consideration for admission to and/or for Services provided to me by AdventHealth, Physicians and Care Providers, which includes independent contractors, I irrevocably assign, transfer and convey the Program and Benefit Plan benefits payable and all right, title and interest in and to such benefits, compensation or payment received or to be received for the Services provided to me by AdventHealth, Physicians and Care Providers (collectively "Benefits") to AdventHealth, Physicians, Care Providers, and their assignees. I irrevocably authorize payment of my Benefits directly to AdventHealth, Physicians, Care Providers and their assignees, to be applied to my Account. I understand that assigning my payment of Benefits will not relieve me of obligations to pay AdventHealth, Physicians, Care Providers, and their assignees, for charges that are not covered by this assignment. If assignment or direct payment is not permitted, I agree to direct my Benefit Plan to make checks or drafts jointly payable to (i) the beneficiary or covered person and (ii) AdventHealth, Physicians, Care Providers, or their assignees, and to send payment to me in care of AdventHealth, Physicians, Care Providers, or their assignees. I also give permission for AdventHealth, Physicians and Care Providers to seek payment in full for charges from parties who injure me or others who may be obligated to pay for my care and their insurers even if Benefits are payable by a managed care payer on my behalf. I agree to pay the difference between the amount my insurance pays and AdventHealth, Physicians or Care Providers' charges (as limited by law or contract) except when AdventHealth, Physicians or Care Providers have a contract(s) with a Benefit Plan that will not let them collect that difference from me and/or the subscriber.

If my Benefit Plan includes a self-funded/insured plan under ERISA or other type of Benefit Plan, in order to help me get my Benefits: I irrevocably authorize and appoint AdventHealth, Physicians, Care Providers or their assignees to be my representative and attorney-in-fact, when AdventHealth, Physicians, Care Providers or their assignees agree in writing to so act in taking all actions needed to get payment, appealing any adverse benefit determination or requesting any reconsideration and to receive notices on my behalf for this purpose. I will follow the procedures required by ERISA or my Benefit Plan for this authorization, if any.

4. Honesty and Cooperation Statement. I promise that my (i) payment sources and insurance coverage information and (ii) any completed insurance applications are true and correct to the best of my knowledge. I agree to give my insurance or financial assistance information timely. I agree to pay all charges that could have been filed if deadlines are missed due to my dishonesty or non-cooperation.

5. Consumer Report Consent. I authorize AdventHealth, Physicians and Care Providers, or their assignees, to get consumer reports about me from one or more consumer reporting agencies to assist AdventHealth, Physicians and Care Providers, or their assignees, with their business activities related to billing, collecting, instituting payment arrangements, and/or determining eligibility for uncompensated care and/or government programs for past, current or upcoming Services at the hospital or outpatient center (whether or not such Service did, may, or will involve an extension of credit) or to resolve any outstanding Account balances. I understand

AdventHealth, Physicians and Care Providers or their assignees may obtain consumer reports about me for Services at the hospital or outpatient center without my written permission under some circumstances as permitted by law. Consumer reports will not be pulled for Services provided at AdventHealth Medical Group or Centra Care locations.

6. Credit Balances. I give permission to apply any credit balances to pay for amounts due to AdventHealth, Physicians, and Care Providers for current Accounts or accounts I have not paid yet.

7. Hospital Laboratory Bills. Testing of fluids/specimens in AdventHealth's laboratory at the hospital is performed under the supervision of a Physician (i.e., pathologist) who may not perform the test or review results, but who does supervise and monitor reporting of the laboratory test results to ordering Physicians. As permitted by law, I AUTHORIZE PAYMENT BY MY BENEFITS FOR THE PHYSICIAN/PATHOLOGIST SUPERVISORY SERVICES. I understand I will not be billed for these supervisory services at the AdventHealth laboratory if my Benefits deny reimbursement.

CONSENT TO SHARING HEALTH INFORMATION:

I give consent to AdventHealth, Physicians and Care Providers to share the following health information as permitted by law and described below:

a. What Health Information: My name, address, contact information, financial information, diagnoses, treatment information which includes HIGHLY CONFIDENTIAL SUBSTANCE ABUSE, MENTAL HEALTH AND HIV/AIDS INFORMATION AS WELL AS INFORMATION IDENTIFIED IN THE ADVENTHEALTH JOINT NOTICE OF PRIVACY PRACTICES AS SUBJECT TO SPECIAL STATE LAWS, and any other information that is part of my health record with AdventHealth.

b. For What Purposes: Treatment, payment, and healthcare operations and as further described in the AdventHealth Joint Notice of Privacy Practices.

c. To Whom:

- Any person or entity responsible for (i) paying for or determining if I am eligible for payment for my treatment or for assigning my Benefits, and (ii) their healthcare operations.
- Physicians or Care Providers or my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, hospice, government or private agency which may provide medical, mental health, rehabilitation, social or related Services to me during a visit with, or during or upon my discharge or transfer from an AdventHealth facility.
- Physicians who have not treated me at AdventHealth, but who have my written permission to access my health information.
- Business partners (and their agents and vendors used to provide the services) of AdventHealth, Physicians or Care Providers who provide administrative, operational, financial, billing and collection, legal and technical support services.
- AdventHealth's affiliates, which are other entities owned or managed by AdventHealth or other physicians who are part of integrated physician or plan networks.
- AdventHealth's institutionally related foundation for fundraising purposes, but only when I have received treatment at the hospital and then only my name, address, contact information, age, gender, dates of services, health insurance status, department where services were provided in the hospital, treating physician(s), and outcome information.
- Recipients who are required or permitted by law to have access to my health information.

d. How Will It Be Shared: Hand delivery, mail, and electronically such as but not limited to electronic mail, facsimile, and through health information exchanges. Health information exchanges are entities that store and/or transfer health information electronically among providers to treat patients. This consent means that AdventHealth, Physicians and Care Providers may access my health information through health information exchanges and share my health information with other health care providers through health information exchanges. I understand my highly confidential information will be part of my health information shared or accessed.

e. Can I Stop Sharing My Health Information: Please review the AdventHealth Joint Notice of Privacy Practices and ask AdventHealth for the Request to Restrict Use and Disclosure of Protected Health Information form.

_____ (Initial Here) I give consent to AdventHealth, Physicians and Care Providers to use, share and access my health information as permitted by law and described above.

CONSENT TO CONTACT:

By signing this Agreement, I understand that I am giving permission to AdventHealth, Physicians, and Care Providers, and their independent contractors, agents, and assignees to call me and send messages (for example, text messages, emails, and chat messages etc.) to me at any time, at any telephone number including any current or subsequently obtained cellular or wireless number that I am a user or subscriber of that is provided by me or given to AdventHealth by a third party helping AdventHealth collect my debt, by using an automatic telephone dialing system or an artificial or prerecorded voice, for any purpose related to my healthcare and treatment, including prescription refill and appointment reminders, billing or collecting payment for my care (including financial assistance options), recommending possible treatment options or health-related benefits and services, and transportation arrangements. Consent to contact you for payment as described above continues until you tell us to cancel your consent or you make payment in full or AdventHealth, Physicians or Care Providers waive or cancel your payment.

You may opt out of receiving certain types of text messages from AdventHealth at any time by texting STOP each time a message is sent to you from us. However, you must opt out of receiving text messages through the AdventHealth app by selecting your communication choices within the AdventHealth app. You may contact AdventHealth at any time to opt out of receiving auto-dialed or pre-recorded voice calls. AdventHealth reserves the right to have an AdventHealth staff member personally call you at any time about your treatment or payment for our Services.

EFFECTIVE PERIOD:

_____(Initial Here) I understand this Agreement is effective during the calendar year I sign it and until I sign it again.

ANY HANDWRITTEN CHANGES TO THIS FORM SHALL NOT BE LEGALLY BINDING OR ENFORCEABLE. I HAVE READ THIS AGREEMENT OR HAVE HAD IT READ TO ME. IT HAS BEEN EXPLAINED TO MY SATISFACTION.

DATE: _____TIME:_____Signature:_____

IF THE SIGNATURE ABOVE IS NOT THE PATIENT'S, WRITE THE NAME AND RELATIONSHIP OF THE PERSON SIGNING FOR THE PATIENT BELOW.

DATE: _____ TIME:_____ Relationship:_____
(e.g., Parent, Guardian, Health Care Surrogate, Guarantor, Proxy, Power of Attorney)

Printed Name: _____

EMPLOYEE SIGNATURE IF PATIENT OR LEGAL REPRESENTATIVE IS NOT ABLE/UNWILLING TO SIGN.

Reason Patient Unable/Unwilling To Sign:_____

DATE: _____TIME:_____Signature: _____

IF INTERPRETER SERVICES ARE USED.

DATE: _____TIME:_____Signature:_____

Please write the interpreter name, badge ID number, language translated, method of translation (phone, video, or in-person), and interpreter signature if translation is in-person:

Interpreter Name:_____

Badge ID Number:_____

Language Translated:_____

Method of Translation:_____