BAPTIST HOSPITAL, INC. – CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

1. Medical and Surgical Consent.
   a. I recognize that I have a condition requiring medical care, and I hereby consent to such medical care and treatment and such diagnostic tests at Baptist Hospital, Inc. (the "Hospital"), as the physicians and staff at the Hospital may deem necessary or advisable. I hereby consent to photographs, videos, digital images that may be recorded to document my care or used for internal education, performance improvement or scientific purposes. I consent to any x-ray examination, laboratory procedures, urine drug screen, blood drug screen, anesthesia, medical, surgical or dental treatment or Hospital services rendered to me under the general and special instructions of the physician/dentist.
   b. I understand that if I am pregnant, my physician may determine that it is necessary to take urine or blood samples to perform drug screens, and I consent to both the taking of the samples and the performance of the screens.
   c. I understand and acknowledge that this facility participates in the education of health care personnel and that students may be involved in the care I receive.
   d. I understand that an explanation of the risks, benefits and alternatives of any medical or surgical procedure performed by my physician will be explained to me by my physician except in an emergency situation.
   e. I UNDERSTAND AND AGREE THAT, AS A PATIENT, MY ATTENDING PHYSICIAN IS DIRECTING MY CARE, AND I RECOGNIZE THAT NONE OF THE PHYSICIANS PROVIDING CARE TO ME INCLUDING, BUT NOT LIMITED TO, EMERGENCY ROOM PHYSICIANS, SURGEONS, RADIOLOGISTS, PATHOLOGISTS AND ANESTHESIOLOGISTS, ARE EMPLOYED BY THE HOSPITAL. PHYSICIANS HAVE PERMISSION TO USE THE HOSPITAL FACILITIES AND MAY TAKE EMERGENCY CALLS FOR THE HOSPITAL BUT ARE INDEPENDENT CONTRACTORS AND NOT AGENTS OR EMPLOYEES OF THE HOSPITAL EVEN THOUGH THEY MAY WEAR GARMENTS OR IDENTIFICATION THAT INCLUDE THE HOSPITAL'S NAME OR LOGO. **I EXPRESSLY AGREE TO RELEASE AND DISCHARGE THE DUTY OF THE HOSPITAL AS TO SERVICES THAT MAY BE PERFORMED BY PHYSICIANS WHO ARE INDEPENDENT CONTRACTORS, BUT NOT EMPLOYEES, OF THE HOSPITAL. I UNDERSTAND THAT BY RELEASING AND DISCHARGING THE HOSPITAL OF ITS DUTY AS TO THESE SERVICES, I AM GIVING UP THE RIGHT TO HOLD THE HOSPITAL LIABLE FOR THE POTENTIAL NEGLIGENCE OF THE PHYSICIANS.**

2. Release of Information. I authorize the Hospital to disclose all or any part of my record, including my medical records, to any person or entity that may be liable to the Hospital or me for all or part of the Hospital's charges, including, but not limited to: a) hospital or medical service companies; b) insurance companies; c) workers' compensation carriers; d) welfare or social services agencies; e) my employer; f) any entity that provides pharmaceutical products or services to the Hospital for my benefit and that offers reimbursement to the Hospital for the provision of those products and services. All such disclosures will be conducted in accordance with applicable laws. I further agree to release the Hospital, its employees, agents and assigns, and representatives from any and all liability arising out of the release of my records pursuant to this paragraph.
3. Consent for Testing and Sharing of Test Results. If, in the course of my medical care, a health care worker is exposed to my blood or other bodily fluids, I give consent for a sample of my blood to be tested for HIV or Hepatitis B antibodies. I understand and acknowledge that the health care worker will be notified of the results for purposes of his or her treatment. I will also be notified of the results.
4. Personal Valuables. I understand the Hospital is not responsible for the safekeeping of my personal belongings such as money, jewelry, dentures, hearing aids, eyeglasses, watches, credit cards, or phones.
5. Assignment of Insurance Benefits. I assign payment of all applicable insurance payments directly to the Hospital and agree that the Hospital may receive any such payment, and I further understand and agree that I will be responsible for charges not covered by this assignment. I assign any state disability benefits to which I may be entitled. I appoint the Hospital as my legal representative under Florida Statutes sec. 316.066 for the sole purpose of obtaining police or crash reports and other data related to the accident or incident for which I sought treatment at the Hospital.
6. Medicare-Medicaid Patients Certification. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all records, including but not limited to medical records. required to act on this request and that payment of authorized benefits be made directly to the Hospital and the physicians involved in my care for any services furnished me by the Hospital and said physicians.

CNT

Patient Identification

8. Patient Information Packet. I acknowledge that I have been offered Hospital's Patient Admission Packet, which includes the notice of patients' rights and the Notice of Privacy Practices.
9. Emergency Care. I understand that if I come to the Hospital's dedicated emergency department seeking care, I will be screened for an emergency medical condition and, if I have an emergency medical condition, the Hospital will provide stabilizing treatment, admit me to the Hospital as an inpatient, or transfer me if medically needed. The screening and the stabilization will be provided **regardless of my ability to pay.** I certify that the Hospital has not withheld, delayed, or conditioned screening or stabilizing care based upon my signing or refusing to sign this paragraph or based upon any payment related concerns.
10. Obligation to Pay My Hospital Bill. I acknowledge that I am financially responsible for my Hospital bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance, and I agree to pay them promptly. If my insurance does not pay my claim after reasonable attempts by the Hospital, I may be responsible for paying my entire bill to the Hospital.
11. Financial Assistance. **I understand the Hospital has financial assistance programs available to those individuals who are unable to pay for their care, based upon a determination of financial need.** By signing below, I acknowledge that the Hospital's financial assistance policy is available to me on the Hospital's webpage or, will be made available to me upon request from the person who provided me this form. I understand I may be asked to provide my personal financial information and/or submit to a credit check in order to qualify for the financial assistance program. If I do not qualify for a financial assistance program, I understand that I may be able to enter into a payment plan with the Hospital.
12. Patient Contact. I authorize the Hospital, its service providers (including service providers contacting me about obtaining potential financial assistance for my account(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using prerecorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.
13. Video Surveillance. I consent to video surveillance monitoring throughout the Hospital's facilities for safety purposes, which may include my private hospital room with appropriate notice.
14. COVID-19 Precautions. I understand that my physician and the Hospital are closely monitoring the situation with the novel coronavirus, COVID-19, and have put in place reasonable precautions to protect me from contracting it during my procedure or hospital stay. However, given the nature of the virus, I understand that despite these precautions, there is a risk I may contract COVID-19 during my procedure or hospital stay. My physician has explained to me that if I currently have COVID-19 (detected or undetected) proceeding with any elective procedures might lead to higher chance of complications.
15. Pelvic Examinations. I understand that Florida law requires my written consent for a pelvic examination. A pelvic examination is an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, urogenital system, prostate or external pelvic tissue or organs. These examinations may be necessary to diagnose or treat conditions that involve the pelvis and may be performed using a gloved hand or instrument. This may be done while I am awake or under anesthesia. I hereby consent to a pelvic examination if my provider deems it medically necessary as part of my care or treatment.

_____

Patient or Patient's Representative (if patient is minor or unable to sign) Relationship to Patient Date and Time

_____

Witness

If patient is a minor, the parent must also complete the following:
The undersigned guarantees and agrees to pay to the Hospital on demand for any and all indebtedness of the patient to the Hospital relating to services provided pursuant to this consent form.

_____

Guarantor Date and Time

_____

Guarantor (Print Name)

Revised 7/2020

CNT

Patient Identification

Baptist Medical Group
Patient Consent and Responsibility Agreement

Welcome to Baptist Medical Group (BMG). We understand you have many choices when it comes to health care and we are glad you chose our medical group. We look forward to providing you with quality health care that is accessible, comprehensive, team-based, coordinated, and focused on your health and safety. Please review the following patient responsibilities, sign and return.

CONSENT FOR TREATMENT. I consent to all services as ordered or performed by my BMG physician, advanced practice provider, or their assistants and designees. This care may include, but is not limited to, medical examination and treatment, administration of drugs or vaccines, nursing care, laboratory, and x-ray procedures. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me about the results of any treatment.

OBLIGATION TO PAY MY BMG BILL: I understand that all charges for services rendered are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my provider bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by a third party payor, and I agree to pay the bill promptly.

MEDICAL INSURANCE: I authorize BMG to bill my health plan or other applicable insurer or third party payor and I assign to BMG all of my rights and claims for reimbursement by a third party payor. I authorize BMG to release to all third party payors any medical information that is required in order for BMG to receive payment for its services to me. I will inform my provider of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire provider bill if my third party payor refuses to pay after reasonable attempts to collect from the third party payor.

APPOINTMENTS: I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be rescheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance may result in a $25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

AUTHORIZATIONS AND REFERRALS: I understand that I am responsible for notifying the practice if my third party payor requires pre-authorizations for tests or for referrals to specialists. I understand the BMG office staff may assist me with scheduling referrals or diagnostic testing, but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

FINANCIAL ASSISTANCE: I understand there are financial assistance programs available for patients who are unable to pay for their care based upon a determination of financial need in accordance with Baptist Health Care's Financial Assistance Policy. I understand it is my responsibility to contact a Patient Account Specialist at BMG's business office at (850) 469-2000 to request financial assistance or access the policy and application at https://ebaptisthealthcare.org/PatientFinancialResources. I agree to provide my personal financial information and/or submit to a credit check to determine if I qualify for financial assistance. If I do not qualify for financial assistance and do not have insurance third party payor, I understand and agree that I will pay in full for all services at the time of service. If I do not have insurance, I may be eligible for a discount when full payment is made at time of service.

RETURN CHECK POLICY: I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write, and will pay these fees upon notice.

BUSINESS HOURS: I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need (one that does not require emergency treatment). I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

PRESCRIPTIONS AND/OR REFILLS: I understand that requests for new medication and/or refills should be made during my visit with my provider. If I need a prescription refill between visits, I agree to contact the practice or my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider.

PATIENT FORMS COMPLETION: I understand that an office visit may be necessary if I request the provider complete certain forms for me. There may also be a nominal fee, payable in advance, for the completion of these forms. I understand these requests may take up to 14 days for processing.

PATIENT PORTAL: I understand this practice may have a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the patient portal which may be accessed at https://ebaptisthealthcare.org/PatientPortal.

WIRELESS COMMUNICATION: By providing a wireless or mobile telephone number, I give permission to my provider to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from the practice and its authorized agents.

NOTICE OF PRIVACY PRACTICES: I understand that Baptist Health Care's Notice of Privacy Practices provides information about how my health information may be used and disclosed. I have been offered and (if requested by me) received a copy of the Notice of Privacy Practices.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND CONSENT TO TREATMENT BY BMG AND I AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.

Patient/Personal Representative Signature	**Date**
Print Patient/Personal Representative Name	**Personal Representative's relationship to patient:**

Dear Patient,

Thank you for choosing Baptist Medical Group Internal Medicine & Pediatrics- Navarre to provide you with compassionate care for your health care needs. We look forward to providing you with the quality health care you deserve.

Our goal is to provide excellent care to our patients while respecting their valuable time. In order to keep the clinic moving smoothly we ask that you complete the new patient paperwork prior to your appointment. Also, please bring a list of your current medications, as well as your insurance card(s) and picture ID. Please arrive 30 minutes early, as this allows time for the staff to enter pertinent information before seeing the provider.

Our office hours are Monday - Friday, 8 a.m. to 4:30 p.m.

Please be sure to carefully read the enclosed Patient Responsibility Disclosure Statement. It gives you information about our office policies and procedures. This is valuable information that will enable us to provide you with quality health care.

If you have any questions, please do not hesitate to contact our office at 850.936.6211. Again we thank you for choosing Baptist Medical Group Internal Medicine & Pediatrics - Navarre.

Healthy Regards,

Baptist Medical Group Internal Medicine & Pediatrics – Navarre

Alison S. Curtsinger, M.D. / Cheryl Jeffries, M.D.

8880 Navarre Parkway, Suite 206, Navarre, FL 32566/ P 850.936.6211 / F 850.936.6410

Baptist Medical Group

Welcome: Please complete the following health history before you see your physician.

Name _____ Birthdate _____ Age _____ Date _____

Date of Last Tetanus shot _____ Last Flu Shot _____ Last Pneumonia Shot _____ Shingles Shot: _____
Last Dilated Eye Exam _____ Last Colonoscopy _____ Last Cholesterol Test _____ Last Bone Density Test: _____

Female
Date of Last Mammogram _____
Date of Last Pap smear _____
Have you ever had an abnormal Pap smear?
☐ No ☐ Yes If yes, date: _____

Male
Date of Last PSA _____

Chief complaint: (current symptoms)
1. _____
2. _____
3. _____

Past Medical History: Please mark if you have ever had:

	Yes		Yes		Yes
Alcoholism		Depression		Respiratory Disease (e.g. COPD)	
Allergies (Seasonal, Environmental)		Diabetes		Seizure Disorder	
Anemia		Heart Arrhythmia/Palpitations		Sexually Transmitted Infection	
Anxiety Disorder		Heart Attack or Bypass Surgery		Steroid Use	
Arthritis		Heart Disease		Stomach Ulcer	
Asthma		High Blood Pressure		Stroke	
Birth Defects		High Cholesterol		Thyroid Disorder	
Blood Clots		Kidney Disease		Tobacco Use	
Blood Transfusion		Liver Disease		Other:	
Bone Fracture		Osteoporosis			
Cancer: Type		Reflux			

Please list any surgeries you have had below and the approximate dates:

1.	Date:	4.	Date:
2.	Date:	5.	Date:
3.	Date:	6.	Date:

Family History: Please indicate the relationship of the family member who has had any of the following: (e.g. father, sister, grandparent)

	Who		Who		Who
Blood Clots		Diabetes		Prostate Cancer	
Breast Cancer		Heart Disease		Stroke	
Colon Cancer		Osteoporosis or hip fracture			
Depression		Ovarian Cancer			

Father: Age (if Living) _____ Age at death (if Deceased) _____ Cause of death _____
Mother: Age (if Living) _____ Age at death (if Deceased) _____ Cause of death _____
Sibling: Age (if Living) _____ Age at death (if Deceased) _____ Cause of death _____
Sibling: Age (if Living) _____ Age at death (if Deceased) _____ Cause of death _____
Sibling: Age (if Living) _____ Age at death (if Deceased) _____ Cause of death _____

Social History:
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of children: _____
Tobacco Use: ☐ Never ☐ Current: # packs per day ____ ☐ Previous: began in year _____ quit in year _____
Alcohol Use: ☐ Current ☐ Previous: began in year _____ quit in year _____ Never
Approximate number of alcoholic drinks per day _____ per week _____ per month _____
Exercise: Number of sessions per week _____ Type _____
Caffeine: Never Yes Amount per day: _____ Type _____
Occupation: _____
Recent Travel: ☐ None ☐ Out of State ☐ Out of Country Location: _____

Do you have an Advanced Directive: Yes No Does this office have a copy? Yes No

Name _____ Birthdate _____ Age _____ Date _____

Allergies: Please list any allergies to medications or foods. Example of reactions: rash or hives, trouble breathing, nausea

Name	Reaction	Name	Reaction
1		4	
2		5	
3		6	

Medications: Include prescription and over-the-counter medications. Feel free to attach a list of medications.

Name	Dose	Frequency

Patient: _____

DOB: _____

Date: _____

General:	Yes	No
Chills		
Fatigue		
Fever		
Night Sweats		
Weight Gain		
Weight Loss		
Other:		
_____		

Head/Neck:	Yes	No
Ear Drainage		
Ear Pain		
Eye Discharge		
Eye Pain		
Hearing Loss		
Nasal Drainage		
Sinus Pressure		
Sore Throat		
Visual Changes		
Excessive Snoring		
Trouble Swallowing		
Other:		
_____		

Lung:	Yes	No
Chronic Cough		
Cough		
Known TB Exposure		
Shortness of Breath		
Wheezing		
Other:		
_____		

Heart/Blood Vessels:	Yes	No
Chest Pain		
Edema		
Palpitations		
Passing out		
Other:		
_____		

GI:	Yes	No
Abdominal Pain		
Blood/Changes in Stool		
Constipation		
Diarrhea		
Heartburn/Reflux		
Loss of Appetite		
Nausea		
Vomiting		
Other:		
_____		

Urinary:	Yes	No
Painful Urination		
Blood In Urine		
Excessive Urination		
Urinary Frequency		
Urinary Retention		
Urinary Incontinence		
Dribbling		
Slow Stream		
Other:		
_____		

Hormone:	Yes	No
Brittle Hair		
Brittle Nails		
Hair Changes		
Cold Intolerance		
Heat Intolerance		
Excessive Hair Growth		
Excessive Thirst		
Excessive Eating		
Other:		
_____		

Brain/Nerves/Spine:	Yes	No
Dizziness		
Numbness in Limbs		
Weakness in Limbs		
Gait Disturbance		
Headache		
Memory Loss		
Seizures		
Tremors		
Frequent Tingling		
Other:		
_____		

Mental Health:	Yes	No
Anxiety		
Depression		
Insomnia		
Other:		
_____		

Skin:	Yes	No
Contact Allergy		
Hives		
Mole Changes		
Rash		
Skin Lesion		
Other:		
_____		

Musculoskeletal:	Yes	No
Back Pain		
Joint Pain		
Joint Swelling		
Muscle Weakness		
Neck Pain		
Other:		
_____		

Blood/Lymphnodes:	Yes	No
Easy Bleeding		
Easy Bruising		
Swollen Lymph Nodes		
Other:		
_____		

Immune System:	Yes	No
Environmental Allergies		
Food Allergies		
Seasonal Allergies		
Other:		
_____		

Female:	Yes	No
Abnormal Pap		
Irregular Periods		
Heavy Period		
Painful Periods		
Vaginal Discharge		
Vaginal Itching		
Breast Lump		
Breast Discharge		
Pain with Intercourse		
Other:		
_____		

Male:	Yes	No
Discharge		
Testicular Pain or Mass		
Erectile Problems		
Hernia		
Penile Discharge		
Other:		
_____		

Questions for the Physician: _____

_____

_____