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 Health Care Corporation, 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. My consent, as signified by my signature below, shall apply to my child if born during my admission or treatment at Hospital.

   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, HOSPITALISTS, 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.

Patient Identification

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 physician involved in my care for any services furnished me by the Hospital and said physicians.

7. Indigent Drug Program. If I qualify for assistance, I agree to comply with the policies of the Hospital's drug program for indigents, which may provide me with replacement of certain medications and/or copay assistance. I consent to participate in this program and authorize the Hospital to sign all forms and applications pertaining to patient assistance and co-pay programs on my behalf.

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. Payment 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. Children born during Admission or Treatment. My consent to all of the elements set forth above, shall also apply to any child of mine who is born during admission or treatment at Hospital.

_____

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

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)

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.

CNT

Patient Identification

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:**

Patient Identification

PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

Date of Birth: _____ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** _____

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Unknown/Declined to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

Home phone: (_____)_____ cell phone: (_____)_____ work phone: (_____)_____

Best daytime number to reach you: ☐ home ☐ work ☐ cell Is it ok to leave a message at any of the numbers? ☐ Yes ☐ No

If no, please designate which ones, if any: _____

Primary Care Physician's Name (if applicable): _____ How did you hear about us? _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Birth date (mm/dd/yyyy): _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

INSURANCE INFORMATION

Primary Insurance Coverage: _____ Copay: $_____

Policy effective date: _____ Deductible: $_____ Met? ☐ Yes ☐ No If no, amount met: $ _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Secondary Insurance Coverage: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Communication with Family Members and Friends Involved In Patient Care

This form documents my request to allow family members and/or friends to be involved in relevant ***verbal discussions*** regarding my health care. By signing this form, I permit Baptist Medical Group ("BMG") staff to discuss information about me with the people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgment of your provider, needs to be shared.

I understand that signing this form is voluntary and that I am not required to sign this form in order to receive health care.

I understand that information may be released to family members or others without this form, if allowed by federal and state law.

I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf.

I understand that my health care provider will discuss only the information that the person involved needs to know about my care or treatment.

I can update this form at any time by completing a new form and giving it to BMG staff.

I understand that BMG staff will verify the identity of the people below (if not known to the staff) prior to discussing this information.

I understand that this is not a Health Insurance Portability and Accountability Act (HIPAA) authorization form that would allow the people below to have access to my written Protected Health Information

Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship
Name	Phone Number	Relationship

Signature	_____	
Print Name	_____	
Date	____ / ____ / _____	Time ____ : _____

Relationship to Patient

- ☐ Self
- ☐ Legal Representative or Guardian (proof of power of attorney or legal guardianship required)

Patient Name: _____ DOB: _____

Today's Chief Complaint: _____ Referring Doctor: _____

PATIENT MEDICAL HISTORY

Please **circle** any medical problem(s) you have had in the past or may currently have.

Medical Problem:	Date:	Medical Problem:	Date:	Medical Problem:	Date:
Breast Cancer		Low White Blood Cells		Heart Disease	
Colon Cancer		High White Blood Cells		Hypertension	
Head and Neck Cancer		Other Blood Disorder		Migraines	
Lung Cancer		Allergies		Obesity	
Ovarian Cancer		Asthma		Renal disease	
Prostate Cancer		Autoimmune disease		Seizure disorder	
Other Cancer:		Cardiovascular disease		Sickle cell	
Anemia		Coronary artery disease		Stroke	
Low Platelets		Depression		Thyroid Disorder	
High Platelets		Diabetes		Other:	

PATIENT SOCIAL HISTORY

Please **circle** below and provide frequency of use:

Tobacco Usage (current or former): Yes No	What Type of Tobacco: Cigarettes Cigars Smokeless Tobacco	Start Date: Stop Date:
Packs/Amount per day:		
Alcohol Consumption: Yes No	Frequency: Daily Weekly Monthly	Amount per Frequency:

PATIENT SURGICAL HISTORY

Please list any past surgeries you may have and provide the date beside it.

_____

_____

_____

MEDICATION HISTORY

Allergy	Severity (Minor, Moderate, Major)	Reaction

Please list **current medication(s)** or provide a list: _____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please **circle** any relevant family medical history. If circled, please write in onset age and relationship to patient.

	Onset Age & Relationship		Onset Age & Relationship		Onset Age & Relationship
Breast Cancer		Low White Blood Cells		Heart Disease	
Colon Cancer		High White Blood Cells		Hypertension	
Head and Neck Cancer		Other Blood Disorder		Migraines	
Lung Cancer		Allergies		Obesity	
Ovarian Cancer		Asthma		Renal disease	
Prostate Cancer		Autoimmune disease		Seizure disorder	
Other Cancer:		Cardiovascular disease		Sickle cell	
Anemia		Coronary artery disease		Stroke	
Low Platelets		Depression		Thyroid Disorder	
High Platelets		Diabetes		Other:	

Patient Signature: _____ **Date:** _____

Patient Name:_____
DOB:_____

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Black or Tarry Stool
- ☐ Change in Bowel Habits
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Indigestion
- ☐ Mucous in Stool
- ☐ Stool Incontinence

Musculoskeletal

- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Lesions
- ☐ Rash
- ☐ Throat Pain
- ☐ Coated Tongue/Mucous Membranes
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Voice Changes
- ☐ Dryness

Neurological

- ☐ Confusion/Memory Loss
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness
- ☐ Weakness
- ☐ Change in Consciousness
- ☐ Unsteadiness
- ☐ Change in Speech
- ☐ Difficulty Speaking
- ☐ Difficulty with Ambulation
- ☐ Tingling
- ☐ Loss of Balance
- ☐ Seizures
- ☐ Unusual Sensation

Heme/Lymph

- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Pleuritic Chest Pain
- ☐ Wheezing
- ☐ Difficulty Breathing on Exertion
- ☐ Shortness of Breath at Rest
- ☐ Sputum Production

Genitourinary

- ☐ Painful/Difficult Urination
- ☐ Hematuria/Blood in Urine
- ☐ Sexual Dysfunction
- ☐ Urinary Frequency
- ☐ Urinary Hesitance
- ☐ Urinary Incontinence
- ☐ Change in Bladder Habits

Performance Level (please circle):

0 Fully active

1 Able to do light work, but not strenuous work/exercise

2 Up and about most of the day; able to care for self, but not work

3 In bed/chair most of the day; need help taking care of self

4 Need to be in bed/chair all the time; cannot take care of self

Patient Name: _____
DOB: _____

General

- ☐ Anorexia
- ☐ Chills
- ☐ Fever
- ☐ Malaise/Fatigue
- ☐ Weight Loss
- ☐ Feeling Well
- ☐ Compliance with Diet
- ☐ Dietary Changes
- ☐ Medication Changes

Skin

- ☐ Jaundice/Yellow Skin
- ☐ Lesions
- ☐ Pruritus/Itching
- ☐ Rash
- ☐ Varicose Veins
- ☐ Normal
- ☐ Skin Color Change
- ☐ Tattoo/Piercing

Breast

- ☐ Breast Lump
- ☐ Nipple Discharge
- ☐ Tenderness
- ☐ Swollen Glands
- ☐ Swelling
- ☐ Nipple Pain
- ☐ Recent Breast Changes

Eye

- ☐ Itching
- ☐ Lacrimation/Watery Eyes
- ☐ Pain
- ☐ Light Induced Pain
- ☐ Vision Changes
- ☐ Discharge
- ☐ Visual Disturbances
- ☐ Dryness

Ear

- ☐ Discharge
- ☐ Hearing Disturbance
- ☐ Hearing Loss
- ☐ Pain
- ☐ Tinnitus/Ringing in Ears
- ☐ Pulling Ear

Nose

- ☐ Congestion
- ☐ Discharge
- ☐ Nose Bleeds
- ☐ Obstruction
- ☐ Sneezing
- ☐ Decreased Sense of Smell
- ☐ Running Nose

Mouth/Throat

- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Lesions
- ☐ Rash
- ☐ Throat Pain
- ☐ Coated Tongue/Mucous Membranes
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Voice Changes
- ☐ Dryness

Respiratory

- ☐ Cough
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Pleuritic Chest Pain
- ☐ Wheezing
- ☐ Difficulty Breathing on Exertion
- ☐ Shortness of Breath at Rest
- ☐ Sputum Production

Cardiovascular

- ☐ Chest Pain
- ☐ Claudication/Leg Pain
- ☐ Lower extremity Swelling
- ☐ Shortness of Breath
- ☐ Palpitation
- ☐ Fainting
- ☐ Feels Faint at Times
- ☐ Irregular Heartbeat

Endocrine

- ☐ Change in Weight
- ☐ Cold/Heat Tolerance
- ☐ Hot Flashes
- ☐ Increased Thirst
- ☐ Excessive Urination

Gynecological

- ☐ Change in Menses
- ☐ Pain During Intercourse
- ☐ Vaginal Discharge
- ☐ Vaginal Pruritus
- ☐ Vulvar Swelling

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Mood Problems
- ☐ Fearful
- ☐ Suicidal Thoughts
- ☐ Delusions

Patient Name: _____

DOB: _____

(For Staff Use Only)
Prescriptions needing refill

Drug Name	Refilled	Discontinued	Added
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

BAPTIST MEDICAL GROUP

CONTROLLED SUBSTANCE AGREEMENT

The State of Florida has laws governing the prescription of controlled substances. These drugs include all opioids (such as codeine, hydrocodone and oxycodone), sleeping aids, benzodiazepines (such as Valium, Xanax and Ativan) and ADHD medications (such as Concerta, Metadate CD, Ritalin and Vyvanse). To comply with Florida law, I acknowledge and agree to the following:

- Prescriptions for most controlled substance medications can only be written for a 30 day supply.
- I will not use any illegal controlled substances, such as marijuana and cocaine.
- I will not share, sell or trade my medication with anyone.
- I will safeguard my medicine from loss or theft. Lost or stolen prescriptions, written or filled, will not be replaced.
- I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time. If requested by my doctor, I will bring all unused pain medicine to every office visit.
- I will request refills of my controlled substance only during an office visit or during regular office hours. No refills will be available during evenings or on weekends.
- I must be seen by my doctor no less than every 3 months to continue to get refills.
- I will submit to a blood or urine test within 24 hours of when requested by my doctor to determine my compliance with these policies and my program of pain control medicine.
- I will communicate fully and truthfully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.
- I will obtain all controlled medicines **only** from the physician listed below. If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to this office in the original bottle, even if there are no pills left**.**
- I acknowledge controlled substance medications have inherent risks associated with their use. These risks include but are not limited to the following: Physical dependence, Psychological dependence, potential for overdose, and potential for withdrawal syndrome.

I agree to comply with the terms of this agreement. I understand that my physician has the right to discontinue prescribing me controlled substance medications and discharge me from care if I do not comply with the terms of this agreement. I hold Baptist Medical Group and its staff harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement.

I agree to use _____ (pharmacy), located at _____ (address) for filling prescriptions for all of my controlled substance medications. If my pharmacy location changes, I will promptly notify the office.

Patient Name: _____ DOB: _____ Date: _____

Patient Signature: _____

Physician Name: _____

Physician Signature: _____

ADVANCE DIRECTIVES:

Speak for Yourself

A Guide to Understanding Advance Directives and Living Wills

This document was prepared to provide information in general terms on health care advance directives and to explain Baptist Health Care's policies and procedures governing advance directives. This is general information and not specific advice. You may want to consult your personal attorney, spiritual advisor, family and friends before completing any advance directive. Signing an advance directive is not a condition of admission or continued stay in this facility.

A Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertinent to health care advance directive. The law requires the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her decisions; and/or to indicate the desire to make an anatomical donation after death.

By law, hospitals are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives.

Questions About Health Care Advance Directives

What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make and anatomical donations after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing when they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might want to choose one, two, or all three of these forms.

What is a living will?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. Your can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

What is an anatomical donation?

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or a donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form, or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative, or a close friend. The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may want to consult one.

However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed, and dated. However, you can also change an advance directive by oral statement; physical destruction of the signed advance directive; or by writing a new advance directive. If your driver's license or state ID care indicates you are an organ donor, but you no longer wish this designation, contact the nearest driver's license office to cancel the donor designation.

What if I filled out an advance directive in another state and need treatment in Florida?

An advance directive that is properly completed in another state as described in that state's law can be honored in Florida.

What should I do with my advance directive if I choose to have one?

- If you designate a health care surrogate be sure to ask them to agree to take this responsibility, discuss how you would like matters handles, and give them a copy of the document.
- Make sure your health care provider, attorney, spiritual advisor, and the significant persons in your life know that you have an advance directive and where it is located. You may also give them a copy.
- Keep a copy in a place where it can be easily located, such as a file of important papers. Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that state you have an advance directive and where it is located.
- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, spiritual adviser, or the significant persons in your life.

What are some other options?

Durable Power of Attorney

As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information.

Do Not Resuscitate Order

If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest.

Advance Directives in the Outpatient Setting

Unlike in an inpatient acute care hospital setting, outpatient clinics and procedural areas do not routinely perform high risk procedures. Therefore, unless your doctor specifically writes a Do Not Resuscitate Order, it is Baptist's policy that resuscitative or other stabilizing measures will be performed on you if any clinical deterioration occurs during your outpatient treatment, regardless of the contents of your advance directive or DNRO.

Resources for more information and/or assistance

- Baptist Hospital's Care Management Department – 850.469.2096
- Gulf Breeze Hospital's Case Management Department – 850.934.2044
- Jay Hospital's Social Services Department – 850.675.8061
- http://www.floridahealthfinder.gov
- projectgrace.org
- Your personal attorney

EMPATH CHOICES FOR CARE | empath health

BAPTIST HEALTH CARE

APPOINTMENT of HEALTHCARE SURROGATE and LIVING WILL

I, _____, want to choose how I will be treated by my healthcare
PRINT NAME
providers. If I am unable to communicate or make my healthcare decisions because of illness or injury, I want my healthcare providers, **healthcare surrogate** (**HCS**) and loved ones to follow this living will.

In the event that I am unable to communicate or make my medical decisions, my HCS may:

- Talk to my healthcare providers and have access to my medical information
- Authorize my treatment or have it withdrawn based on my choices
- Authorize transportation to another facility
- Make decisions regarding organ/tissue donation based on my choices
- Apply for public benefits, such as Medicare/Medicaid, on my behalf

PART 1: CHOOSE A HEALTHCARE SURROGATE (HCS)

In the event that I am unable or unwilling to communicate or I am incapable of making my decisions about receiving, withholding or withdrawing medical procedures or other treatments, I designate my healthcare surrogate (HCS) to make choices for me according to his/her understanding of my choices and values.

My Appointed HCS

Name:_____

Address:_____

Phone:_____ Alternate phone:_____

Email:_____

Alternate HCS (If my appointed HCS is unwilling, unable, or not reasonably available)

Name:_____

Address:_____

Phone:_____ Alternate phone:_____

Email:_____

HEALTHCARE SURROGATE AUTHORITY (HCS)

My HCS's authority becomes effective when my healthcare provider determines that I am unable to make my own healthcare decisions, unless I initial either or both of the following statements.

If I initial here _____ my HCS's authority to receive my health information takes effect immediately. (upon signing this document)

If I initial here _____ my HCS's authority to make healthcare decisions for me takes effect immediately. (upon signing this document)

While I am able to make my own decisions, my choices will determine the kind of medical treatment I will receive. My healthcare providers will clearly communicate with me about my treatment and any changes even if I allow my HCS to make decisions immediately.

PART 2: INDICATE YOUR MEDICAL CHOICES

I understand that this living will only becomes effective when I am:

1. No longer able to communicate or when I am not capable of making my healthcare decisions known **AND**
2. Two physicians have determined that I have one of the following:
   - ⇒ A terminal or end-stage condition and there is little or no chance of recovery
   - ⇒ A condition of permanent and irreversible unconsciousness, such as a coma or vegetative state
   - ⇒ An irreversible and severe mental or physical illness, such as end-stage dementia, that prevents me from communicating with others, recognizing my loved ones or caring for myself in any way

If I develop one of these conditions, I want my healthcare providers and my HCS to follow the choices I have made in this living will.

My specific choices if I have one of the above conditions	**Circle Your Choice**	
Cardio-pulmonary resuscitation (CPR) if my heart and breathing stops	Yes I Want	No I Do Not Want
A breathing machine (ventilator) if I am unable to breathe on my own	Yes I Want	No I Do Not Want
Nutrition and fluids through tubes in my veins, nose or stomach	Yes I Want	No I Do Not Want
Kidney dialysis, a pacemaker or a defibrillator, or other such machines	Yes I Want	No I Do Not Want
Surgery or admission to a hospital Intensive Care Unit	Yes I Want	No I Do Not Want
Medications that can prolong my dying, such as antibiotics	Yes I Want	No I Do Not Want

Place your initials by the statements below that are important to you.

_____ I want my HCS and my healthcare providers to ensure my comfort and the management of my pain. I understand that the use of pain medications may cause side effects, such as drowsiness or confusion.

_____ I want palliative care provided to ensure my comfort.
(Palliative care provides relief from the symptoms, pain and stresses of any serious illness. Palliative care can be provided along with curative treatment.)

_____ To ensure my comfort, I want hospice involved in my care at the earliest opportunity.
(Hospice care focuses on comfort and quality of life rather than a cure.)

PART 3: INDICATE GOALS OF CARE

This page is optional, but highly recommended.

Suppose there is a time when you are too sick or hurt to communicate. Your healthcare providers believe there is little chance you will recover the ability to know who you are or who you are with. What would be most important to you in this situation? (level of care, location of care, description of a good quality of life) _____

What cultural, spiritual, religious or personal beliefs do you have that you want your healthcare providers to know about? (customs, practices, meals, services, music)

Please contact my religious/spiritual advisor to support me.

Name:_____

Contact information:_____

I want my HCS, loved ones, and healthcare providers to know these things about me. What fears, worries or concerns do you have about serious illness or injury?_____

PART 4: MAKE IT LEGAL

I fully understand the meaning of this Appointment of Healthcare Surrogate and Living Will. I am emotionally and mentally capable of signing this document. This document reflects my personal choices regarding medical care.

Signature _____ Printed name _____ Date _____

Witness 1: _____ _____
Print name Signature

Address: _____

Witness 2: _____ _____
Print name Signature

Address: _____

**** Your healthcare surrogate(s) cannot serve as a witness to this living will. At least one witness must be someone other than your spouse or a blood relative.***

Next Steps

- ☐ Discuss your living will with your healthcare provider(s).
- ☐ Communicate your choices to your HCS and alternate surrogate.
- ☐ Once your living will has been signed and witnessed, give copies to: your doctor(s), your HCS and alternate surrogate and your loved ones.
- ☐ Keep your original copy where it can be easily found.
- ☐ Review your living will on a regular basis. A living will can be changed at any time.

Copies of this document have been given to:_____

_____

*The state of Florida does **NOT** require notarization of living wills, however some states do. Please check your state's requirements. This space is being provided for those individuals who need notarization.*

Signature: _____ County of: _____

The foregoing instrument was acknowledged before me on _____ (date).

By: _____ Signature of Notary: _____

Seal of Notary:

- This request must be made in writing and tell us how you would like to be contacted.
- We will agree to reasonable requests.

- **Right To Amend:**
  - You can ask us to change your medical information. For example, you can ask us to correct errors such as your date of birth.
  - This request must be made in writing to the appropriate office listed at the end of this Notice with an explanation as to why the amendment is being requested.
  - The law does not require us to agree to your request. If we deny your request, we will notify you in writing, including the reasons for the denial.
  - If we deny your request to change your medical information you can appeal our decision. Your appeal must be made in writing.
- **Right To An Accounting:**
  - You can ask us to give you a list of disclosures we have made of your medical information within the six years prior to your request.
  - This list will not include every disclosure made including those disclosures made for treatment, payment and healthcare operations purposes.
  - This also does not include information shared at your request.
  - This request must be made in writing to the appropriate office listed at the end of this Notice.
  - If you request more than one accounting in a twelve-month period, we may charge you a fee.
- **Right To Be Notified In The Event Of A Breach:**
  - We will notify you if your medical information has been used or disclosed in a way that is not consistent with law and results in your medical information being compromised.
- **Right To A Paper Copy Of This Notice:** If asked, we will give you a paper copy of this Notice.

Other Use Of Your Medical Information Without Your Authorization:

- We will not share your medical information except in the ways indicated in this Notice unless you give us your written authorization to do so.
- Most uses and disclosures of psychotherapy notes and uses and disclosures for marketing purposes fall within this category and require your authorization.
- With certain limited exceptions, we are not allowed to sell or receive anything of value in exchange for your medical information without your written authorization.
- If you provide us authorization to use or disclose medical information about you, you may revoke (withdraw) that authorization, in writing, at any time. However, uses and disclosures made before your withdrawal are not affected by your action and we cannot take back any disclosures we may have already made with your authorization.

Questions or Complaints

We ask that you please give us the opportunity to resolve any issues you have concerning your privacy. If you feel that we have violated your privacy, you may file a written complaint with the Baptist Health Care Privacy Officer at the address below. If you prefer, we will be happy to assist you in completing a written complaint. **There will be no retaliation against you for filing a complaint.** For further information or assistance, you may contact us at:

Privacy Officer
Baptist Health Care Corporation
Governance, Risk & Compliance (GRC)
1717 North E Street, Suite 409; Pensacola, FL 32501
850.434.4472

You also have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services but we ask that you first allow us the opportunity to correct any issues you may have concerning your privacy.

Effective Date: June 1, 2015

NOTICE OF PRIVACY PRACTICES

BAPTIST HEALTH CARE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Pledge Regarding Your Medical Information

Your privacy is important to us. The law requires us to maintain the privacy of your medical information and to tell you our duties and practices regarding your medical information. The law requires us to follow the terms of our current Notice. We reserve the right to make changes to this Notice, which may include new privacy provisions about the medical information that we already have about you as well as any information we receive in the future. If we make any changes, we will give you a copy of the new Notice the next time you visit us. The latest version of this Notice can always be found on our website at www.ebaptisthealthcare.org. In addition, you may request a copy of the Notice currently in effect.

We are providing this Notice so that you understand:

- Who will follow this Notice
- How we may use and share your medical information
- Your rights concerning your medical information
- How to file a complaint about your privacy

Who Will Follow This Notice:

This notice applies to all Baptist Health Care providers providing health care to the public at all of its delivery sites including, but not limted to:

- Andrews Institute Rehabilitation
- Baptist Hospital
- Baptist Medical Group
- Baptist Medical Park – Nine Mile
- Baptist Medical Park – Navarre
- Baptist Medical Park Surgery Center
- Baptist Occupational Health
- Baptist Physician Group
- Baptist Physician Associates
- Baptist Urgent Care
- Cardiology Consultants
- Gulf Breeze Hospital
- Jay Hospital
- The Towers Pharmacy
- All health care professionals, employees, medical staff, trainees, students and volunteers of Baptist Health Care

This Notice does not include Lakeview Center, Inc., or those physicians who are not employed by Baptist Health Care. Those providers should provide you a separate Notice that explains how they will collect, use and disclose your medical information.

How We May Use and Share Your Medical Information:

- **Treatment Purposes:** We may share your information with those who are caring for you. For example, if you come in with a broken arm, we will give your x-rays to your doctor. If you need medication, the doctor may share your information with your pharmacist.
- **Payment Purposes:** We may share your medical information with the person or company paying for your care. For example, if you come to us with a broken arm, we will tell your insurance company why you came in and what we did for you.
- **Health Care Operations:** We may use your medical information to improve the way we provide care to you and others. For example, we may share your medical information to teach others.
- **Health Information Exchange:** We may share your medical information with other health care providers for treatment, payment and health care operations as permitted by law through an approved Health Information Exchange (HIE). Exchange of medical information

can provide faster access, better coordination of care and assist providers and public health officials in making more informed treatment decisions.

- **Appointment Reminders:** We may contact you to remind you about your appointment. Please tell us if you do not want your information used in this way.
- **Sign-in Sheets:** We may use sign-in sheets in our offices and call your name when the doctor is ready to see you.
- **Treatment Choices and Health Promotions:** We may send you information about different ways to treat you and about other health benefits or services that you may want to know about.
- **Fundraising:** We may contact you to provide information about BHC sponsored activities, including fundraising programs and events to support research, education or patient care at BHC. For this purpose, we may use your contact information, such as your name, address and phone number, the dates on which and the department from which you received services, your treating physician's name, your treatment outcome, and your health insurance status. The communication you receive will have instructions on how you may ask us not to contact you again for such purposes, also known as an "opt-out".
- **Research:** We may share your information for research. The law requires us to take extra steps to protect your privacy and tell why we will be using your information.
- **Hospital Directory:** We may use your information in our directory. Our directory has your name, religion, room number and how you are doing. If someone asks for you by name we will tell them your room number and how you are doing. We may allow members of the clergy to see our directory even if they do not ask for you by name. Please tell us if you do not want to be listed in our directory.
- **People Involved In Your Care:** We may share your medical information with a family member or a friend who is involved in your care. We may also share your information with a person or company who is helping pay your bill. Please tell us if you do not want your information shared in this way.
- **Disaster Relief:** If there is a disaster such as a hurricane, plane crash or tornado we may use your medical information to notify your family. We may also release information to an agency such as the Red Cross. Please tell us if you do not want your information shared in this way.
- **Satisfaction Surveys:** We may use your information to contact you requesting feedback on the services provided to you by BHC. Your answers will help us provide better care to our patients and the community we serve.
- **Special Programs:** If you sign-up for one of our programs such as Golden Care, we may share your health information with our volunteers and others so they can check on you while you are in our care.
- **Security Cameras:** To increase the level of security in our facilities, we sometimes use security cameras and recorders in public areas such as hallways and parking lots. We do not use these devices in any private areas such as patient or exam rooms unless doing so is part of the treatment we provide

How We May Share Your Medical Information Without Your Permission:

- **As Required By Law:** An example is the mandatory reporting of positive cancer tests to State agencies.
- **To stop a serious threat to someone's health or safety:** We may only share this information with someone who can stop the threat.
- **For Public Health:** We may share your medical information with a public health agency such as the Centers for Disease Control.
- **Law Enforcement:** In some situations we may share your medical information with law enforcement. If we believe you are a victim of abuse or some other crime we may tell the police. We may also tell the police if you commit a crime at our facility.
- **State and Federal Review:** We may share your medical information when being reviewed. For example we may share your information with Medicare or Medicaid when they are reviewing the way we provide care.
- **Legal Proceedings:** We may share your medical information when responding to proper requests in legal proceedings.
- **Children:** In some cases we may not share your child's medical information with you. For example, there are times when your child can seek care without your permission.
- **Organ Donation:** If you are an organ donor we may share your medical information when appropriate.
- **In Case of Death:** We may share your medical information with a medical examiner or funeral director.
- **Military and Veterans:** If you are in the military or a veteran, we may share your medical information when required by law.
- **National Security:** We may share your medical information when required by law for national security purposes.
- **Protection of the President and others:** We may share your medical information when required by law for protection services of the President and other important leaders.
- **Department of State:** We may share your medical information when required for security clearances and physicals of State Department personnel and their dependents.
- **Inmates:** If you are a prisoner or in police custody, we may share your medical information when required by law.
- **Work Injuries:** If you are getting care because you were hurt at work we may share your medical information with your employer and others as required by Workers' Compensation laws.

Health Information With Additional Protections

Certain types of medical information may have additional protection under federal or state law, for example, if you are receiving behavioral health services from us, your name will not be listed in our Hospital Directory and will not be shared for fundraising purposes. Also, federally assisted alcohol and drug abuse programs are subject to special restrictions on the use and disclosure of related treatment information

Your Rights Concerning Your Medical Information:

- Right To Request Restrictions:
  - You can ask us not to share your medical information for treatment, payment and health care operations. Usually, we will not agree to this request because it would make it difficult for us to care for you.
  - You can ask us not to share your medical information with family or friends who are involved in your care.
  - If you want to make any of these requests you must do so in writing. The law does not require us to agree to your request.
  - If you need emergency treatment we may share your medical information even if you have asked us not to.
  - As of September 23, 2013, if you request that we not disclose certain medical information to your health insurer and that medical information relates to a health care product or service for which we have received payment from you in full, then we must agree to that request.
- Right To See And Get A Copy:
  - You have the right to see and get a copy of your medical information for as long as we have it.
  - We may charge a fee for giving you a copy.
  - Sometimes the law does not allow us to let you see your medical information. If this happens, you can appeal our decision. Your appeal must be made in writing.
- Right To Request Confidential Communications:
  - You can ask us to contact you in certain ways. For example, you can ask that we not send your bills or appointment reminders to your home address or call you at your work number.