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

CNT

Patient Identification

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. 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) Date of Birth 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)

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:**

PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Address: _____

Address cont (apt. #, lot #, etc) _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

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 #: _____

☐ Verified Patient Information Staff Initials: _____

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 Cardiology Consultants (CC) 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 CC staff.
- I understand that CC 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 #:*	*Relationship:*
Name:	*Phone #:*	*Relationship:*
Name:	*Phone #:*	*Relationship:*
Name:	*Phone #:*	*Relationship:*

Signature of Patient (or Parent/Legal Guardian if Patient is a Minor): _____

Printed Name of Patient: _____DOB:_____

Date: _____

Relationship to Patient (if applicable):_____

Radiation Oncology Initial Consult

Name_____DOB:_____Date_____

Referring Doctor_____
Surgeon _____
PCP _____

Other physicians you would like us to send your medical information to:

_____
_____
_____

Describe reason for visit (include symptoms, tests, surgeries, physician visits)

_____
_____

List serious medical conditions

_____ _____
_____ _____
_____ _____
_____ _____

Please list prior surgical procedures with year they were performed

Biopsy: Date/Dates: _____
Month/Year_____Procedure_____
Month/Year_____Procedure_____
Month/Year_____Procedure_____
Month/Year_____Procedure_____

Do you have any implanted devices (pacemaker, hip, knee)?

_____

Have you had prior radiation therapy or chemotherapy?

When? _____
Where? _____
_____
_____

Family History

Has any close relative had cancer? Please list relationship and type of cancer

_____ _____

_____ _____

Social History

Alcohol use _____ Cigarettes/cigar/pipe/chew_____

For Office Use:

Counselled to stop smoking: _____ Materials given: _____

_____

RN signature Date/Time

Review of Systems (please circle)

Flu Shot _____ Pneumonia Shot _____ Living Will _____

Constitutional: fatigue, fever, weight loss

Eyes: blurred vision, pain in eyes, double vision, glaucoma, eye disease or injury

Neurologic: headaches, seizures, paralysis, stroke, dizzy spells, not alert, not oriented

Endocrine: diabetes, thyroid disease, glandular or hormone problem

Gastrointestinal: nausea, vomiting, constipation, diarrhea, rectal bleeding, ulcerative colitis

Cardiovascular: heart trouble, high blood pressure, chest pain, irregular heart beat

Integumentary: skin rash, boils, skin disease

Musculoskeletal: arthritis, bone or joint pain

Ear/nose/throat: ear ache, sinus problems, sore throat, difficulty swallowing, hoarseness

Respiratory: asthma, emphysema, coughing up blood, shortness of breath

Hematologic/lymphatic: swollen glands, blood clotting problem, blood thinners

Psychological: anxiety, depression

Rectal: bleeding, pain, irritation, hemorrhoids, urgency Last colonoscopy:_____

GU: urinary frequency, urgency, burning, bleeding, incontinence, drainage, erectile dysfunction

Breasts: discharge, pain, tenderness Last mammogram: _____

Gyn: heavy discharge, last period: _____

Your age when you delivered your first and last child: _____

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

For Office Use:

Wt _____ Ht: _____ B/P: _____ P _____ T _____ R _____ Pain: _____

*History completed by patient, reviewed and updated by nurse: _____

Reviewed and dictated by: _____

(MD signature/date/time)

PATIENT REFERRAL FORM

American Cancer Society

Notice to Patient

The American Cancer Society (ACS) offers services and information that could help you while you are dealing with your cancer. Please sign below if you agree that your doctor (or Health Care Provider) may share your information with the ACS. They will then contact you about the cancer information, services and resources that you request.

Patient Signature: _____ **Date:** _____

The ACS cares about your privacy and will protect and use your information only in accordance with its Privacy Policy, available at www.cancer.org. The ACS will use the information contained on this form to contact you about the services you have requested.

With your permission given below, the ACS may also use your information to contact you about other programs and services that may be of interest to you, to invite you to events in your community, and/or to tell you about volunteer or other support opportunities. If you would like to give the Society permission to contact you regarding these other opportunities, please initial here: _____ **(Patient Initials)**

If you have questions about your cancer, the ACS, its programs, services or privacy standards, or to change your contact preferences, please visit **www.cancer.org** or call **1-800-227-2345. The ACS is available 24 hours a day, 7 days a week.**

Provider Information

Healthcare Provider Name: Baptist Hospital — ACS ID: 1-2HLWOCI

Referral Contact Name: Radiation Oncology — Phone: (850) 469 – 2200

Patient Information *(Minimum of one method of contact required). Information shared here will assist us in efficiently coordinating services.*

Patient Name: (required)

Primary Address: ☐ Home ☐ Business ☐ Other

City: *State:* *Zip Code:*

Primary Phone: ( ) – ☐ Home ☐ Cell ☐ Business

Alternate Phone: ( ) – ☐ Home ☐ Cell ☐ Business

Email: ☐ Personal ☐ Business

Date of Birth: *ex: MM/DD/YYYY* | Primary Language: ☐ English ☐ Spanish ☐ Other: *Please List*

Race: ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Two or more races ☐ Declined to Share ☐ Other: *Please List*

Gender: ☐ Female ☐ Male

Diagnosis

Date of Diagnosis: *ex: MM/DD/YYYY* | Type of Cancer: ☐ Recurrence

Insurance: ☐ Medicaid ☐ Medicare ☐ Medicare + Medicaid ☐ Medicare + Private ☐ Military ☐ Private ☐ Uninsured ☐ Declined to Share

☑ Personal Health Manager Requested (Kit to organize your cancer and treatment information) ☐ English ☐ Spanish ☐ Other Language: *Please List*

Requested Services

Best Time to Call: *ex: 00:00* ☐ AM ☐ PM | OK to leave a message: ☐ Y ☐ N

☐ Transportation to cancer treatment | First Date Needed: *ex: MM/DD/YYYY* | Time: *ex: 00:00* ☐ AM ☐ PM

☐ Lodging during cancer treatment | First Date Needed: *ex: MM/DD/YYYY*

☐ One-on-one breast cancer support (Reach to Recovery) | Treatment Type: ☐ Early Support ☐ Lumpectomy ☐ Mastectomy ☐ Chemotherapy ☐ Radiation ☐ Advanced

☐ Classes to enhance appearance & self-esteem during treatment (Look Good Feel Better) | Skin Tone: ☐ Dark ☐ Extra Dark ☐ Light ☐ Medium

☐ Resources/Referrals for other needs:

Comments/Other information you would like us to know:

Healthcare Provider Instructions: The Notice above regarding American Cancer Society's use of information must be shared with the patient prior to submitting this form to the American Cancer Society. ACS will rely on Health Care Provider's submission of any Patient Referral Form as evidence that this Notice has been communicated to patient. Once completed, please fax form to **877-428-2862** or Email form to **SSBCREF@CANCER.ORG**

PRW1A