

**CONDITIONS FOR TREATMENT AND
FINANCIAL RESPONSIBILITY**

Side 1 of 2

Any reference to “ChristianaCare” in this consent includes actions by ChristianaCare, its employees, contractors, and associated medical providers. Unless I otherwise withdraw my consent in writing, I consent to the following:

CONSENT FOR TREATMENT

- A. ChristianaCare may obtain my health and insurance coverage information, including my healthcare treatment and prescription history, and provide health services to me. I understand and agree that there is no guarantee of any specific outcome of health care services provided. I understand this consent applies to inpatient and outpatient hospital-based services, as well as all ambulatory office-based services I obtain from ChristianaCare.
- B. ChristianaCare is a teaching institution and professional trainees may participate in my care.
- C. ChristianaCare may use photographic, video, electronic, or audio media during or as part of some treatments (e.g., trauma, infant resuscitation) for performance improvement, patient identification, training and/or treatment purposes and this may be recorded. I understand that these recordings may be reviewed by the healthcare professionals but will not become a part of the medical record and will be erased after review.

TELEHEALTH

- A. I understand that “telehealth” is the mode of delivering health care services using digital communication technology to help evaluate, diagnose, consult, educate, monitor, and manage care and treatment without being in the same physical location as my provider.
- B. I understand that a telehealth visit is not the same as an in-person visit because I will not be in the same room with my provider. I understand that I will not be treated through telehealth unless my condition supports the use of this technology as my provider will not be able to perform some aspects of a full physical examination.
- C. I understand that digital communication technology may include, but not be limited to real time two-way audio, video, or other telecommunications or electronic communications, including remote patient monitoring, secure video conferencing, and/or secure texting with my care team.
- D. I understand that there are benefits to utilizing telehealth services, which include, but are not limited to, convenient medical evaluation and management. I also understand that there are risks involved in receiving treatment through telehealth, which include, but are not limited to interruption in the audio/video connection that may result in the visit being postponed until a later time and/or performed through an alternate method, and, in rare cases, unauthorized access to my confidential information. In the event of a technical failure, I understand that I should immediately contact my provider’s office, or, if it is an emergency, dial 911.
- E. I understand that laws protecting the confidentiality of my medical information also apply to telehealth and that ChristianaCare uses security protocols to help protect my privacy and ensure my confidential communications are sent only to the intended care team member(s).
- F. I understand that ChristianaCare will not record the video or audio of my telehealth visit without my consent at the time of the recording.
- G. I consent to have ChristianaCare obtain health information from me and provide health care services to me through telehealth communications when and where my provider or qualified member of my care team determines it is appropriate and necessary.
- H. I understand that I may refuse or stop participation in telehealth services and request alternate services, such as an in-person visit, at any time.

RELEASE FROM LIABILITY FOR VALUABLES

- A. I am responsible for loss or damage to personal property brought to a ChristianaCare facility, except for belongings placed in the hospital’s safe. I release ChristianaCare from all claims for lost, stolen or damaged property.
- B. If I am hospitalized, I agree that the maximum liability of the hospital for loss of any belongings placed in the hospital safe is limited to \$300 unless the hospital gives me a written receipt for a greater amount.

FINANCIAL RESPONSIBILITY

- A. I agree that I am financially responsible to ChristianaCare and other physician groups (e.g., Emergency Department, Anesthesiology, Pathology) for all charges for healthcare services provided to me during my visit.
- B. I understand I am responsible for charges which are not otherwise covered by government and/or commercial insurance coverage.

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Side 2 of 2

<p>FINANCIAL RESPONSIBILITY (continued)</p> <p>C. I understand that ChristiananaCare only recognizes commercial and/or government health care plans as insurance coverage and does not recognize cost sharing programs as insurance coverage. I understand that if I am not covered by a commercial or government health care benefit plan, I will be considered a self-pay patient. I understand I am responsible for charges regardless of my participation in a cost sharing program, information set forth on my membership card, and any restrictions set forth on a payment instrument by the cost sharing program.</p> <p>D. Upon getting my bill for services, if I do not meet my financial responsibility in a timely manner, I understand that I may be responsible for additional fees associated with the collection of any unpaid amount.</p> <p align="center">ASSIGNMENT OF BENEFITS</p> <p>A. I assign payment of all insurance or other benefits, under which I am entitled to coverage, to ChristiananaCare, its healthcare contractors and related physician groups, as applicable, for healthcare services provided to me during my patient care visit.</p> <p align="center">MEDICARE ASSIGNMENT OF INSURANCE BENEFITS</p> <p>A. Where Medicare benefits apply, I confirm the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct. I request payment of authorized Medicare benefits to ChristiananaCare and its contracted services and physician groups for any services I receive. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits for related services.</p> <p align="center">PATIENT COMMUNICATIONS</p> <p>A. I consent to ChristiananaCare communicating with me by phone, email, or text message to the telephone number and/or email address provided by me. I recognize and understand that there is a risk of an unintentional disclosure of information, including my protected health information, to a third party, if information is sent via email or text message. I also recognize and understand that my wireless carrier may charge me for text messaging.</p> <p>B. I consent and authorize ChristiananaCare to use my email and telephone number for patient satisfaction surveys, delivery of healthcare information, visit follow up, advertisements, telemarketing purposes, billing matters and collections on an account.</p> <p>C. I consent and authorize ChristiananaCare to use my telephone number and email to communicate with (i) an automatic telephone dialer and/or (ii) pre-recorded calls and/or (iii) text messages.</p> <p>D. I understand that I have a right to opt out of any and all patient communication methods mentioned above if contacted. I also understand that I am not required to provide my consent to all patient communication methods as a condition to receive healthcare services.</p> <p>E. This consent applies to all past, present and future communications from ChristiananaCare until I revoke this consent in writing.</p> <p align="center">NOTIFICATION AND ACKNOWLEDGMENT OF FINANCIAL ASSISTANCE PROGRAM</p> <p>I have been offered the opportunity to receive and review the "Financial Assistance Program Summary."</p> <p align="center">NOTICE OF PRIVACY PRACTICES</p> <p>I have received a copy or have been given the opportunity to review the ChristiananaCare "Notice of Privacy Practices."</p> <p align="center">CONSENT</p> <p>I have read this document or it has been read to me and I understand my responsibility:</p>	<p>Witness Signature _____</p> <p>Print Name _____</p> <p>Date ____/____/____</p> <p>Time _____</p> <hr/> <p>Interpreter Name _____</p> <p>Agency and ID# (if applicable) _____</p> <hr/> <p>The person who provided the interpretation is a qualified medical interpreter.</p> <p>Language _____</p> <hr/> <p>Interpretation: The information has been presented to the: <input type="checkbox"/> patient <input type="checkbox"/> representative <input type="checkbox"/> decision maker in: _____</p> <hr/> <p>Telephone Number _____</p> <p>Email Address _____</p> <hr/> <p>Patient/Representative Signature _____</p> <p>Relationship to Patient _____</p> <p>Date ____/____/____</p> <p>Time _____</p>
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