CITY OF TAMPA ULTRASOUND PREPS AND EXAM TIMES

AORTA ULTRASOUND: NOTHING TO EAT OR DRINK FOR 8 HOURS PRIOR TO EXAM (THIS INCLUDES GUM). PATIENT CAN TAKE MEDICATION WITH A SMALL AMOUNT OF WATER IF NEEDED.
***EXAM TIME = 15 TO 20 MINUTES**

CAROTID ULTRASOUND: NO JEWELRY AROUND NECK.
***EXAM TIME = 15 TO 20 MINUTES**

THYROID ULTRASOUND: NO JEWELRY AROUND NECK.
***EXAM TIME = 15 TO 20 MINUTES**

LIVER, PANCREAS, GALLBLADDER, SPLEEN, AND KIDNEY ULTRASOUND: NOTHING TO EAT OR DRINK FOR 8 HOURS PRIOR TO EXAM (THIS INCLUDES GUM). PATIENT CAN TAKE MEDICATION WITH A SMALL AMOUNT OF WATER IF NEEDED.
***EXAM TIME = 30 MINUTES**

BLADDER ULTRASOUND: PATIENT MUST DRINK 32 TO 44 OUNCES OF WATER AT LEAST ONE HOUR BEFORE SCHEDULED APPOINTMENT TIME. PATIENT MUST NOT USE RESTROOM AND KEEP BLADDER FULL. IF PATIENT IS ALSO SCHEDULED FOR LIVER, PANCREAS, GALLBLADDER, SPLEEN, AORTA, AND KIDNEY, IT IS OKAY TO DRINK CLEAR WATER ONLY AS PREP FOR THIS EXAM.
***EXAM TIME = 15 MINUTES**

PELVIC/TRANSVAGINAL ULTRASOUND (for women only): PATIENT MUST DRINK 32 TO 44 OUNCES OF WATER ONE HOUR BEFORE SCHEDULED APPOINTMENT TIME. PATIENT MUST NOT USE RESTROOM AND KEEP BLADDER FULL. IF PATIENT IS ALSO SCHEDULED FOR LIVER, PANCREAS, GALLBLADDER, SPLEEN, AORTA, AND KIDNEY, IT IS OKAY TO DRINK CLEAR WATER ONLY AS PREP FOR THIS EXAM.
***EXAM TIME = 30 TO 45 MINUTES**

TRANSRECTAL PROSTATE ULTRASOUND (for men only): PATIENT MUST OBTAIN AN OVER THE COUNTER (OTC) FLEET ENEMA KIT FROM PHARMACY. FOLLOW INSTRUCTIONS AND ADMINISTER THE DAY BEFORE THE EXAM. PATIENT MUST ARRIVE WITH CLEAN COLON TO PERFORM.
***EXAM TIME = 15 TO 20 MINUTES**

TESTICULAR ULTRASOUND (for men only): NO PREP FOR THIS EXAM.
***EXAM TIME = 20 TO 30 MINUTES**

Initial Plan of Care

Name:_____ Age:_____

SKIN	❑ Acne ❑ Bruising	❑ Burning Feet ❑ Eczema	❑ Herpes ❑ Itching	❑ Poor Wound Healing ❑ Psoriasis	❑ Rash ❑ Warts
EYES	❑ Blurred Vision ❑ Cataracts	❑ Discharge ❑ Excessive Tearing	❑ Glaucoma ❑ Glasses or Contacts	❑ Sties	
EARS	❑ Earache ❑ Excessive Wax	❑ Hearing Loss ❑ Itching	❑ Pressure ❑ Ringing	❑ Vertigo	
NOSE/SINUS	❑ Allergies ❑ Congestion	❑ Discharge ❑ Frequent Colds	❑ Hay Fever ❑ Nose Bleeds	❑ Sneezing	
MOUTH/THROAT	❑ Bleeding Gums ❑ Canker Sores	❑ Freq Sore Throat ❑ Gingivitis	❑ Hoarseness ❑ Tobacco Use		
RESPIRATORY	❑ Apnea ❑ Asthma	❑ Bronchitis ❑ COPD	❑ Cough ❑ Difficulty Breathing	❑ Pneumonia ❑ Wheezing	
CARDIOVASCULAR	❑ Atherosclerosis ❑ Chest Pain/Tightness ❑ Cold Extremities	❑ Feet Swelling ❑ Heart Murmur ❑ Heart Surgery	❑ High BP ❑ High Cholesterol ❑ Leg Cramps	❑ Low BP ❑ Palpitations ❑ Shortness Of Breath	❑ Edema
GASTROINTESTINAL	❑ Abdominal Pain ❑ Anal Itching ❑ Blood in Stool	❑ Constipation ❑ Diarrhea ❑ Gallbladder Trouble	❑ Heartburn ❑ Hemorrhoids ❑ Hepatitis	❑ Indigestion ❑ Liver Disease ❑ Nausea	❑ Ulcers ❑ Vomiting
URINARY	❑ Blood In Urine ❑ Burning	❑ Frequency ❑ Hesitancy	❑ Infections ❑ Kidney Disease	❑ Urgency ❑ Stones	
GENITAL (MALE)	❑ Discharge ❑ Enlarge Prostate	❑ Hernia ❑ STD's	❑ Testicular ❑ Kidney Disease	❑ Pain/Swelling	
GENITAL (FEMALE)	❑ Abnormal Pap ❑ Birth Control ❑ Breast Pain/Lumps	❑ Discharge ❑ LMP ❑ Irregular Cycle	❑ Heavy Bleeding ❑ Hysterectomy ❑ STD's	❑ Menopause ❑ Spotting ❑ Vaginal Dryness/Discomfort	❑ Hormone Replacement
MUSCULOSKELETAL	❑ Backache ❑ Glucocorticoid Use ❑ Sciatica	❑ Fractures ❑ Joint Swelling ❑ Fibromyalgia	❑ Joint Pain ❑ Muscle Spasms ❑ Gout	❑ Muscle Pain ❑ Muscle Weakness ❑ Limited Motion	❑ Rheumatoid Arthritis
NEUROLOGIC	❑ Dizziness ❑ Tingling ❑ Insomnia	❑ Loss Of Interest ❑ Headaches ❑ Seizures	❑ Stroke/Tia ❑ Poor Coordination ❑ Weakness	❑ Fainting ❑ Tremors	❑ Numbness ❑ Depression
ENDOCRINE	❑ Anemia ❑ Cold Intolerance ❑ Diabetes	❑ Edema ❑ Enlarged Thyroid ❑ Excessive Hunger	❑ Excessive Thirst ❑ Fatigue ❑ Goiter	❑ Hypoglycemia ❑ Hypothyroidism ❑ Hyperthyroidism	❑ Poor Appetite ❑ Weight Gain/Loss
IMMUNE	❑ Anxiety ❑ Autoimmune ❑ Cancer History	❑ Clotting Problems ❑ Easy Bruising ❑ Fever/Chills	❑ Frequent Infections ❑ Hiv Testing ❑ Immunizations	❑ Splenectomy ❑ Swollen Glands ❑ Tuberculosis	

PAST SURGERIES? _____ Yes _____ No	**DO YOU EXERCISE?** _____ Yes _____ No

Alcohol Use? _____ Yes _____ **No Tobacco Use?** _____ Yes _____ No **Illegal Drug Use?** _____ Yes _____ No

Herbal Remedies/Medications? _____
_____
_____
_____

FLORIDA HOSPITAL CARROLLWOOD
Occupational Health Services

OSTEOPOROSIS SCREENING

Last Name:_____ **First Name:** _____ **MI:** ____

QUESTIONS

1.	Do you have a small, thin frame and/or are you Caucasian or Asian?	❑ YES ❑ NO
2.	Have you or a member of your family broken a bone as an adult?	❑ YES ❑ NO
3.	Are you a post-menopausal woman?	❑ YES ❑ NO
4.	Have you been diagnosed with low testosterone man?	❑ YES ❑ NO
5.	Is your diet low in dairy products and calcium?	❑ YES ❑ NO
6.	Are you physically active?	❑ YES ❑ NO
7.	Do you smoke cigarettes or former smoker?	❑ YES ❑ NO
8.	Do you consume greater than 3 drinks of alcohol every day?	❑ YES ❑ NO
9.	Have you been treated for cancer, diabetes with insulin, hemochromatosis or endocrine disorders?	❑ YES ❑ NO
10.	Have you been diagnosed with thinning of the bones?	❑ YES ❑ NO

HAVE YOU EVER TAKEN ANY OF THE MEDICATIONS LISTED BELOW?

SEIZURE MEDICATIONS OR ANTICONVULSANTS

1.	Dilantin-Phenytoin	❑ YES ❑ NO
2.	Mysoline-Primidone	❑ YES ❑ NO
3.	Phenobarbital	❑ YES ❑ NO
4.	Tegretol-Carbamazepine	❑ YES ❑ NO

HORMONE THERAPY

1.	Depo-Provera (Birth Control) (Medroxyprogestrone)	❑ YES ❑ NO
2.	High doses of Thyroid supplement	❑ YES ❑ NO

ANDROGEN DEPRIVATOIN THERAPY (PROSTATE CANCER)

1.	Lupron, Eligard (Leuprolide)	❑ YES ❑ NO
2.	Zoladex (Goserelin)	❑ YES ❑ NO
3.	Trelstar (Triptorelin)	❑ YES ❑ NO
4.	Vantas (Histerlin)	❑ YES ❑ NO
5.	Zytiga (Abeiraterone)	❑ YES ❑ NO
6.	Firmagon (Degarelix)	❑ YES ❑ NO
7.	Xtandi (Enzalutamide)	❑ YES ❑ NO

ARHRITIS MEDICATIONS

1.	Methotrexate	❑ YES ❑ NO
2.	Cyclosporine	❑ YES ❑ NO
3.	Corticosteroids-Medrol, Prednisone	❑ YES ❑ NO

REFLUX OR STOMACH MEDICATIONS: USED FOR 5-7 YEARS OR GREATER

1.	Nexium (Esomeprazole)	❑ YES ❑ NO
2.	Prilosec (Omeprazole)	❑ YES ❑ NO
3.	Prevacid (Lansoprazole)	❑ YES ❑ NO
4.	Aciphex (Rabeprazole)	❑ YES ❑ NO

_____ _____

Patient Signature **Date**

FLORIDA HOSPITAL
CARROLLWOOD
Occupational Health Services

FLORIDA HOSPITAL
CARROLLWOOD
The skill to heal. The spirit to care.®

Audiometric History

Last Name _____ First Name _____ DOB _____

Audiometric History

Do you think your Hearing is: Good ☐ Fair ☐ Poor ☐

Have you ever had:

1. A hearing test ☐Yes No ☐
   Where? _____
2. Ear trouble ☐Yes No ☐
3. Difficulty hearing ☐Yes No ☐
4. Ear surgery ☐Yes No ☐

Have you ever been:

5. Exposed to a loud noise
   At home Yes☐ No☐
6. Knocked unconscious Yes☐ No☐
7. Exposed to gunfire Yes☐ No☐
8. Ringing/noise in your ears Yes☐ No☐
9. Are you exposed to noise on your current job? YES☐ No (if Yes) ☐
   Type of noise:
   Number of hours or minutes/days exposed:
   Number of days/weeks exposed:
   Type of hearing protection used:
10. Have you been exposed to loud noises during the last 14 hours? Yes☐ No☐
    Type of noise:_____
    Date, time and number of hours exposed:_____
    Did you use hearing protection Yes☐ No☐
    If YES, what type?_____
    How many hours or minutes did you use hearing protection?
11. Did you have noise exposure in your previous job or military? Yes☐ No☐
    If YES, explain:_____
    _____
12. Do you have outside activities which expose you to noise? Yes☐ No☐
13. Have you had any ear or hearing problems? Yes☐ No☐
    If YES, explain_____
    _____

AUDIOMETRIC HISTORY FORM
Florida Hospital Carrollwood
Occupational Health Services
Tampa, Florida

Addressograph

Florida Hospital Tampa Bay Division

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

Florida Hospital Tampa Bay Division is affiliated with Adventist Health System (AHS). Except for tailoring this Notice for each AHS facility and specific state laws, all AHS facilities generally follow this same Notice. This Notice applies to all of the health records that identify you and the care you receive at AHS facilities.

http://www.adventisthealthsystem.com/AboutUs/WebsitePrivacyPolicy/AffiliatedEntities.aspx

If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

If you have any questions about this notice, please contact the Florida Hospital Tampa Bay Division's Compliance and Privacy Officer at 813–615–7969.

Section A: Who Will Follow This Notice

This notice describes Florida Hospital Tampa Bay Division's privacy practices and that of:

- Any health care professional authorized to enter information into your medical chart.
- All departments and units of Florida Hospital Tampa, Florida Hospital Carrollwood, Florida Hospital Pepin Heart Institute, and Florida Hospital at Connerton, Long Term Acute Care Hospital.
- Any member of a volunteer group we allow to help you while you are in Florida Hopsital Tampa, Florida Hospital Carrollwood, Florida Hospital Pepin Heart Institute, or Florida Hospital at Connerton LTACH.
- All employees, staff and other personnel of Florida Hospital Tampa, Florida Hospital Carrollwood, Florida Hospital Pepin Heart Institute, and Florida Hospital at Connerton LTACH.
- Florida Hospital Tampa Physician Practices, Florida Hospital Tampa Home Care, Florida Hospital Tampa Diabetes and Endocrinology Institute, Florida Hospital Wound and Hyperbaric Medicine Centers, Florida Hospital Carrollwood Occupational Health Services, The Breast Care Center at Florida Hospital Tampa, The Kirin C. Patel Research Institute, Centers of Excellence.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or hospital operations purposes described in this notice. This list may not reflect recent acquisitions or sales of entities, sites, or locations.

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or maintained by a Florida Hospital Tampa Bay Division facility, whether made by Florida Hospital Tampa Bay Division personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Use our best efforts to keep medical information that identifies you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

We may share your medical information in any format we determine is appropriate to efficiently coordinate the treatment, payment, and health care operation aspects of your care. For example, we may share your information orally, via fax, on paper, or through electronic exchange.

We also ask you for consent to share your medical information in the Admission Agreement you sign before receiving services from us. This consent is required by state law for some disclosures and allows us to be certain that we can share your medical information for the all reasons described below. You may view a list of the main state laws that require consent (Attachment A) by clicking here,

http://www.adventisthealthsystem.com/Portals/1/docs/NPPP/NPP_AttachmentA_StateLaw.pdf

or you may ask the registration clerk for a paper copy. If you do not want to consent to these disclosures, please contact the Privacy Officer to determine if we can accept your request.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.**
  We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Florida Hospital Tampa Bay Division personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of Florida Hospital Tampa Bay Division facilities also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x–rays. We also may disclose medical information about you to people outside Florida Hospital Tampa Bay Division who may be involved in your medical care, such as family members, friends, clergy or others we use to provide services that are part of your care.

- **Payment.**
  We may use and disclose medical information about you so that the treatment and services you receive at a Florida Hospital Tampa Bay Division facility may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at a Florida Hospital Tampa Bay Division facility so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **Health Care Operations.**
  We may use and disclose medical information about you for Florida Hospital Tampa Bay Division's operations. These uses and disclosures are necessary to run Florida Hospital Tampa Bay Division and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may use and disclose your information as needed to conduct or arrange for legal services, auditing, or other functions. We may give out your medical information to our business associates that help us with our adminstrative and other functions. These business associates may include consultants, lawyers, accountants, and other third parties that provide services to us. The business associates may re–disclose your medical information as necessary for our health care operations functions, or for their own permitted administrative functions, such as carrying out their legal responsibilities. We may also combine medical information about many patients to decide what additional services a Florida Hospital Tampa Bay Division facility should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Florida Hospital Tampa Bay Division personnel for review and learning purposes. We may also combine the medical information we have with medical information from other entities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. Once we have removed information that identifies you, we may use the data for other purposes. We may also disclose your information for certain health care operation purposes to other entities that are required to comply with HIPAA if the entity has had a relationship with you. For example, another health care provider that treated you or a health plan that provided insurance coverage to you may want your medical information to review the quality of the services you received from them.

- **Appointment Reminders.**
  We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at a Florida Hospital Tampa Bay Division facility.

- **Treatment Alternatives.**
  We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health–Related Benefits and Services.**
  We may use and disclose medical information to tell you about health–related benefits or services that may be of interest to you.

- **Fundraising Activities.**
  We may use information about you to contact you in an effort to raise money for a Florida Hospital Tampa Bay Division facility and its operations. We may disclose information to a foundation related to a Florida Hospital Tampa Bay Division facility so that the foundation may contact you to raise money for the Florida Hospital Tampa Bay Division facility. We would release only contact information, such as your name, address, phone number, gender, age, health insurance status, the dates you received treatment or services at a Florida Hospital Tampa Bay Division facility, the department you were treated in, the doctor you saw, and your outcome information. If you do not want Florida Hospital Tampa Bay Division to contact you for fundraising efforts, you must notify us in writing.

- **Patient Directory.**
  We may include certain limited information about you in the Florida Hospital Tampa Bay Division facility's patient directory while you are a patient at the Florida Hospital Tampa Bay Division facility. This information may include your name, location in the Hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the Hospital and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care.**
  We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in the Hospital. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.**
  Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects involving people, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, unless most or all of the patient identifiers are removed, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the hospital. If required by law, we will ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at a Florida Hospital Tampa Bay Division facility.

- **As Required By Law.**
  We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety.**
  We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Section D: Special Situations

- **Organ and Tissue Donation.**
  We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.**
  If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may also disclose information to entities that determine eligibility for certain veterans' benefits.

- **Workers' Compensation.**
  We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work–related injuries or illness.

- **Public Health Risks.**
  We may disclose medical information about you for public health activities. These activities generally include the following:

  - To prevent or control disease, injury or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.**
  We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.**
  We may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.**
  We may release medical information if asked to do so by a law enforcement official:

  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at a Florida Hospital Tampa Bay Division facility; and
  - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.**
  We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Hospital to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.**
  We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.**
  We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.**
  If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.**
  You have the right to inspect and copy some of the medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. When your medical information is contained in an electronic health record, as that term is defined in federal laws and rules, you have the right to obtain a copy of such information in an electronic format and you may request that we transmit such copy directly to an entity or person designated by you, provided that any such request is in writing and clearly identifies the person we are to send your PHI to. If you request a copy of the information, we may charge a fee for the costs of labor, copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy medical information in certain circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.**
  If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the hospital;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.**
  You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. The accounting will exclude certain disclosures as provided in applicable laws and rules such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care, disclosures for notification purposes and certain other types of disclosures made to correctional institutions or law enforcement agencies.Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.**

  You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

  We are not required to agree to your request, except in limited circumstances where you have paid for medical services out–of–pocket in full at the time of the service and have requested that we not disclose your medical information to a health plan. To the extent we are able, we will restrict disclosure to your health plan. We will not be able to restrict disclosures of your medical information to a health plan if the information does not relate solely to the health care item or service for which you have paid in full. For example, if you are having a hysterectomy that will be paid for by your health plan, and you request to pay cash for a tummy tuck that you want performed during the same surgery, to avoid disclosure to your health plan, you would either have to pay cash for the entire procedure or schedule the procedures on separate days. Please also know that you have to request and pay for a restriction for all follow–up care and referrals related to that initial health care service that was restricted in order to ensure that none of your medical information is disclosed to your health plan. You, your family member, or other person may pay by cash or credit, or you may use money in your flexible spending account or health savings account. Please understand that your medical information will have to be disclosed to your flexible spending account or health savings account to obtain such payment.

  If we do agree, we will comply with your request unless the disclosure is otherwise required or permitted by law. For example, we may disclose your restricted information if needed to provide you with emergency treatment.

- **Right to Request Confidential Communications.**

  You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Notice of Breach.**

  You have the right to receive written notification of a breach if your unsecured medical information has been accessed, used, acquired or disclosed to an unauthorized person as a result of such breach, and if the breach compromises the security or privacy of your medical information. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first–class mail or, if necessary, by such other substituted forms of communication allowable under the law.

- **Right to a Paper Copy of This Notice.**

  You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website:

  www.elevatinghealthcare.org

- **Right to Decline Participation in Health Information Exchange.**

  AHS has electronically connected the medical information each AHS facility has in your medical record through a series of interfaces, named iNetwork. iNetwork contains a summary of your most relevant medical information that includes at a minimum, available information regarding your demographics, insurance, problem list, medication list, radiology reports, and lab reports. Making your medical information available through iNetwork promotes efficiency and quality of care. You may choose not to allow your medical information to be shared through iNetwork. It is not a condition of receiving care.

If you do not want your medical information shared through iNetwork, please contact the Privacy Officer at the phone number below. Once we process your request, your health care providers will no longer be able to view your medical information in iNetwork. This means that it may take longer for your health care providers to get medical information they may need to treat you.

AHS and its affiliated facilities may also choose to share medical information electronically with other health care providers located near or in the same state as an AHS affiliated facility through regional or state health information exchanges. You may choose not to allow your medical information to be shared through regional or state health information exchanges by either refusing to sign an authorization form or contacting the Privacy Officer at the number below, depending on the consent process of the regional or state health information exchange. This means that it may take longer for your health care providers to get information they may need to treat you. However, even if you do not want to participate in a state health information exchange, certain state law reporting requirements, such as the immunization registry, will still be fulfilled through health information exchange, and some states still allow health care providers to access your medical information through a regional or state health information exchange if needed to treat you in an emergency.

To exercise the above rights, please contact the following individual to obtain a copy of the relevant form you will need to complete to make your request:

Scott Garrett, Director, Compliance and Privacy
Florida Hosptial Tampa, 3100 E. Fletcher Ave., Tampa, Fl 33613
813–615–7969

Section F: Changes To This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in each Florida Hospital Tampa Bay Division facility, as well as on our website;

www.elevatinghealthcare.org

The notice will contain on the first page, in the top right–hand corner, the effective date. In addition, each time you register at or are admitted to a Florida Hospital Tampa Bay Division facility for treatment or health care services as an inpatient or outpatient, we will make available a copy of the current notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with Florida Hospital Tampa Bay Division, contact Scott Garrett, Director of Compliance and Privacy, Florida Hospital Tampa Bay Division, 3100 E. Fletcher Ave, Tampa, FL 33613; 813–615–7969. All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

Section H: Other Uses of Medical Information That Require Your Authorization

The following types of uses and disclosures of medical information will be made only with your written permission.

- **Psychotherapy Notes.**
  Psychotherapy notes are notes that your psychiatrist or psychologist maintains separate and apart from your medical record. These notes require your written authorization for disclosure unless the disclosure is required or permitted by law, the disclosure is to defend the psychiatrist or psychologist in a lawsuit brought by you, or the disclosure is used to treat you or to train students.

- **Marketing.**
  We must get your permission to use your medical information for marketing unless we are having a face–to–face talk about the new health care product or service, or unless we are giving you a gift that does not cost much to tell you about the new health care product or service. We must also tell you if we are getting paid by someone else to tell you about a new health care item or service.

- **Selling Medical Information.**
  We are not allowed to sell your medical information without your permission and we must tell you if we are getting paid. However, certain activities are not viewed as selling your medical information and do not require your consent. For example, we can sell our business, we can pay our contractors and subcontractors who work for us, we can participate in research studies, we can get paid for treating you, we can provide you with copies or an accounting of disclosures of your medical information, or we can use or disclosure your medical information without your permission if we are required or permitted by law, such as for public health purposes.

If you provide us with authorization to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Section I: Organized Health Care Arrangement

The Florida Hospital Tampa Bay Division, the independent contractor members of its Medical Staff (including your physician), and other health care providers affiliated with the Florida Hospital Tampa Bay Division have agreed, as permitted by law, to share your medical information among themselves for purposes of your treatment, payment or health care operations at the Florida Hospital Tampa Bay Division facility. This enables us to better address your health care needs.

By signing this Written Acknowledgment of Receipt of Florida Hospital Tampa Bay Division Notice of Patient Privacy Practices ("Acknowledgment"), I hereby expressly acknowledge my receipt of Florida Hospital Tampa Bay Division Notice of Patient Privacy Practices.

_____

Patient, or Legal Representative, Signature

_____

Printed Patient, or Legal Representative, Name (or label)

_____

Date

Acknowledgment NOT obtained because:

☐ Patient, or legal representative , declined Notice of Patient Privacy Practices ;

☐ Patient treated in emergency room and discharged before obtaining Acknowledgment;

☐ Other (briefly describe) _____

_____

Employee Signature

_____

Employee Printed Name

_____

Date

Patient ID Label

Afix Label Here

Acknowledgement of Notice
Of Privacy Practices

CONSENT TO TREATMENT AND ADMISSION AGREEMENT
(Florida Hospital Carrollwood)

This Admission Agreement and Consent to Treatment pertains to the admission and/or treatment of _____ (the "**Patient**") at **Florida Hospital Carrollwood** (the "**Hospital**"). The Patient and/or the individual signing this Agreement on the Patient's behalf for purposes of consent for medical treatment (the "**Legal Representative**") and/or financial responsibility for the medical treatment received by the Patient (the "**Principal Obligor**") hereby agree to comply with all respective inpatient or outpatient admission, or clinical visit requirements of the Hospital. For purposes of this Agreement, "I," "me", "my" and "myself" refer to the Patient, the Patient's Legal Representative and/or the Patient's Principal Obligor, as appropriate.

1. Consent to Admission and Treatment

I voluntarily agree to the provisions of this Agreement regarding my admission to and/or treatment received at the Hospital as an inpatient, outpatient or clinical patient as the case may be. As part of the course of my care and/or diagnosis and treatment of my medical condition, and based on my understanding of the capitalized/bolded language below I consent to receive services and care, including but not limited to physical examinations, the administration of medications, tests, procedures, blood and blood products (collectively "**Services**") deemed advisable by physicians ("**Physicians**") or other medical professionals practicing at the Hospital, employees of the Hospital, residents or students studying at the Hospital and other Hospital personnel (collectively "**Care Providers**").

I UNDERSTAND THAT THE HOSPITAL FURNISHES THE FACILITIES AND EQUIPMENT THAT MAKES MY RECEIPT OF SERVICES FROM PHYSICIANS AND CARE PROVIDERS POSSIBLE.

I UNDERSTAND THAT NOT ALL OF THE SERVICES RENDERED AT THE HOSPITAL ARE SERVICES OFFERED DIRECTLY BY THE HOSPITAL OR AN EMPLOYEE OF THE HOSPITAL. MANY PHYSICIANS AND CARE PROVIDERS UTILIZING THE FACILITIES AND EQUIPMENT OF THE HOSPITAL ARE INDEPENDENT CONTRACTORS AND ENGAGE IN THE BUSINESS OF RENDERING SERVICES AT THE HOSPITAL FOR THEIR OWN BENEFIT.

PHYSICIANS AND CARE PROVIDERS WHO PROVIDE SERVICES AT THE HOSPITAL AS INDEPENDENT CONTRACTORS, ARE NOT EMPLOYED BY, NOR ARE THEY AGENTS OF, THE HOSPITAL. THIS MAY INCLUDE, BUT IS NOT LIMITED TO, EMERGENCY ROOM PHYSICIANS, RADIOLOGISTS, PATHOLOGISTS, ANESTHESIOLOGISTS, SURGEONS, CARDIOLOGISTS, PULMONOLOGISTS AND NEONATOLOGISTS. THIS MEANS THAT THE HOSPITAL IS NOT RESPONSIBLE FOR, AND DOES NOT AGREE TO ACCEPT THE LIABILITY FOR, SERVICES PROVIDED TO ME BY INDEPENDENT CONTRACTOR PHYSICIANS AND/OR CARE PROVIDERS. OTHER THAN THE HOSPITAL'S OBLIGATION TO PROVIDE FACILITIES AND EQUIPMENT THAT ARE FREE OF KNOWN DEFECTS AND AN ENVIRONMENT THAT IS FREE OF UNREASONABLE RISK, I HAVE BEEN ADVISED THAT THE HOSPITAL UNDERTAKES NO DUTY OR OBLIGATION (AND EXPRESSLY DENIES AND REJECTS ANY DUTY THAT MAY BE SOUGHT TO BE IMPOSED ON IT, WHETHER NON-DELEGABLE OR NOT) TO ASSUME RESPONSIBILITY FOR THE SERVICES I MAY RECEIVE FROM A PHYSICIAN OR CARE PROVIDER WHO IS AN INDEPENDENT CONTRACTOR OF THE HOSPITAL. I UNDERSTAND THAT PHYSICIANS AND CARE PROVIDERS WHO ARE INDEPENDENT CONTRACTORS OF THE HOSPITAL HAVE AN INDEPENDENT DUTY TO ME TO RENDER SERVICES IN A NON-NEGLIGENT MANNER.

ACKNOWLEDGING THAT I HAVE READ AND UNDERSTAND THE ABOVE, AND TO THE EXTENT THAT IT IS DETERMINED AS A MATTER OF LAW THAT THE HOSPITAL HAS A NON-DELEGABLE DUTY TO PROVIDE THE SERVICES RENDERED TO ME BY A PHYSICIAN OR CARE PROVIDER WHO IS AN INDEPENDENT CONTRACTOR OF THE HOSPITAL, I (ON BEHALF OF MYSELF, MY FAMILY, HEIRS OR ASSIGNS) RELEASE AND DISCHARGE THE HOSPITAL FROM ANY SUCH DUTY.

I ALSO ACKNOWLEDGE THAT SOME OF THE PHYSICIANS THAT MAY CARE FOR ME AT THE HOSPITAL ARE FACULTY MEMBERS OR RESIDENTS OF THE UNIVERSITY OF SOUTH FLORIDA COLLEGE OF MEDICINE AND EMPLOYEES OR AGENTS OF THE FLORIDA BOARD OF EDUCATION OR UNIVERSITY OF SOUTH FLORIDA BOARD OF TRUSTEES, AND THAT THEIR LIABILITY, IF ANY, THAT MAY ARISE FROM CARE AND TREATMENT PROVIDED TO ME IS LIMITED BY LAW.

2. Financial Responsibility

In consideration of the Services I will receive during my admission and/or treatment and/or any subsequent related admissions or treatments, including but not limited to, inpatient, outpatient, or clinical visits, I hereby obligate myself to the Hospital, Physicians and Care Providers and agree to pay for any and all charges, expenses and fees incurred or to be incurred in relation to the provision of Services ("**Hospital Account for Services**" or "**Account**"). **I ACKNOWLEDGE THAT THE PHYSICIANS AND/OR CARE PROVIDERS MAY BILL ME SEPARATELY FOR THE SERVICES THEY PROVIDE.** I understand that no credit is being extended to me and that the Hospital Account for Services is immediately due and payable in Hillsborough County, State of Florida.

I authorize the Hospital to obtain credit reports with respect to my credit history from one or more credit reporting agencies at any time regarding past, current or anticipated Services, whether or not such Service did, may or will involve credit, a Delinquent Account or an outstanding Account balance.

IF I HAVE MEDICARE, MEDICAID OR OTHER KINDS OF GOVERNMENT INSURANCE (the "**Program**"), I understand the Program may not cover certain Services I request or that are provided to me by the Physicians or

Afix Label Here

Care Providers if the agency overseeing the Program determines the Services are not reasonable and/or medically necessary or are otherwise not covered by the Program. In accordance with this Agreement and applicable law, I also understand that I may be responsible for payment of any Services I receive if such Services are determined not to be reasonable, medically necessary or are not covered by the Program. **I have received a written statement explaining my rights under the applicable Program, if required.**

IF I HAVE PRIVATE INSURANCE, I AGREE TO BE RESPONSIBLE FOR CO-PAYMENTS, COINSURANCE AND DEDUCTIBLE AMOUNTS required by health insurance plans ("**Insurance Plan(s)**")which are due prior to admission or at the time of admission or discharge and in accordance with the Hospital's policies. In addition to my obligations as set forth in Section 3, I understand that to the maximum extent permissible under the law, I will be responsible for all amounts not paid by my Insurance Plan, and all charges the Hospital could have filed with my Insurance Plan if I fail to provide coverage information in a timely manner which results in the Hospital's inability to meet its filing deadlines.

IF I DO NOT HAVE INSURANCE, I understand that paying the Hospital bill(s) for the Account is my responsibility. Except for Services required to be provided by law, I understand that the Hospital reserves the right to require proof of my ability to pay and may require a deposit or payment in full before admission or treatment. Any deposits shall be applied to my Account.

IF I CANNOT PAY MY ACCOUNT IN FULL TODAY, representatives from the Hospital Financial Services Office will assist me to determine if I may qualify for assistance as provided in the Hospital's policies.

IF I DO NOT PAY MY ACCOUNT AND/OR I AM REFERRED TO A COLLECTION AGENCY, I will pay all the collection costs, expenses and reasonable attorney's fees if my Account is referred to a collection agency or law firm for nonpayment.

I CERTIFY THAT I AM NOT DELINQUENT IN THE PAYMENT OF ANY AMOUNT owed the Hospital on my behalf or on behalf of any person for whom I am legally responsible (a "**Delinquent Account**"). If I am responsible for any Delinquent Account, I have made arrangements for payment at this time.

IF PAYMENT OF THE HOSPITAL ACCOUNT FOR SERVICES UNDER THIS AGREEMENT RESULTS IN A CREDIT BALANCE, I give the Hospital permission to apply the credit balance to offset amounts due under other outstanding Accounts I have with the Hospital, whether current Accounts or Delinquent Accounts. If there are any credit balances related to prior agreements between me and the Hospital, I give the Hospital permission to apply such credit balances to this Account.

I FURTHER CERTIFY THAT THE MEDICAL AND FINANCIAL INFORMATION I WILL PROVIDE IN CONNECTION WITH MY ADMISSION AND/OR TREATMENT AT THE HOSPITAL IS TRUE, COMPLETE AND ACCURATE IN EVERY RESPECT.

I understand that testing blood, urine, or similar bodily fluids/specimens in the Hospital's laboratory is performed under the supervision of a Physician (i.e., pathologist). While this Physician may not actually perform the test or review its results, this Physician is responsible for supervising the Hospital's laboratory to ensure that all laboratory test results are clinically reliable and timely reported to ordering Physicians. To the extent permitted by law, **I UNDERSTAND THAT I WILL RECEIVE A BILL FROM THE PHYSICIAN/PATHOLOGIST FOR SUCH SUPERVISORY SERVICES** and agree to pay all or the portion of the Physician's bill to the extent not paid by my Insurance Plans.

3. Authorization of Coverage and Denial of Coverage

I hereby agree that I am solely responsible for satisfying all conditions and/or procedures (regardless of whether such conditions and/or procedures are before, during or after the provision of Services), that are necessary or appropriate for authorization and/or verification of coverage by the applicable payer of Services, including but not limited to, obtaining pre-certification, pre-authorization, or second opinions. I agree that my failure to satisfy all conditions and/or procedures could result in denial or reduction of payments by the applicable payer of Services. It is further agreed and understood that satisfying all conditions and/or procedures does not relieve my financial obligations herein for Services received from the Hospital, Physicians and/or Care Providers.

I understand that a payer can deny, reduce, or otherwise fail to make full payment for a Service received, or may not be liable for payment for a Service for any reason, including but not limited pursuant to a determination that: (i) the Services are not covered Services; (ii) the payer does not authorize or certify coverage for the Services; (iii) I did not follow the conditions and/or procedures for coverage of the Services, (iv) the Services are not reasonable or medically necessary; or (v) limits of benefit coverage under my plan make me ineligible to receive full or partial coverage for the Services. If I am able to appeal a denial of coverage for a Service and decide to appeal, I will inform the Hospital immediately so that the Hospital may pursue payment only in accordance with applicable law in light of such an appeal. I further understand that, to the extent required by applicable law, I will be provided with: (i) the applicable Program notification of non-coverage of Services; and (ii) an estimate of reasonably anticipated charges by the Hospital in connection with receipt of the notification of non-coverage of Services.

I understand that if a payer denies coverage for a Service or item because the Service or item is not covered by the Program or Insurance Plan (a "Non-Covered Service"), the amount charged to me for each Non-Covered Service on the applicable invoice shall be the lesser of: (i) the Hospital's usual and customary charge for each Non-Covered Service; (ii) if applicable, the amount specified in an agreement between the Hospital and the payer for such Non-Covered Service; or (iii) if applicable, the maximum amount the law permits the Hospital to charge for the Non-Covered Service.

4. Assignment of Benefits

I acknowledge that Services have been and/or will be rendered to me by the Hospital, Physicians and/or Care Providers, and

that I may be entitled to receive payment for these Services under one or more Programs, under one or more Insurance Plans from any other payers, or arising from any claim I might assert against others because of my injuries (my "**Claim**"). In consideration of the Services rendered or to be rendered to me for this admission and/or treatment and/or any subsequent related admission and/or treatment, including, but not limited to, inpatient, outpatient, or clinical visits, I hereby irrevocably assign and transfer to the Hospital, Physicians, Care Providers, and/or their respective assignees, all right, title and interest in all benefits, liens, damages, indemnity, reinsurance or other monies payable for Services rendered, including but not limited to: group medical, indemnity, self-insured or Employee Retirement Income Security Act ("**ERISA**") benefits or coverage; PIP; uninsured/underinsured motorist; auto or homeowner insurance; and in all causes of action against any party or entity that may be responsible for payment of benefits or monies regardless of whether or not I ultimately settle my claim with a non-admission of liability provision. I hereby request, demand and authorize that, to the maximum extent permitted by law (and to the extent not prohibited by an applicable provider contract), payment of Program proceeds, applicable Insurance Plan proceeds, and/or all other benefits as to which I am or may become entitled to for Services, be paid directly to the Hospital, Physicians, Care Providers, and/or their respective assignees. I understand that assignment of such Program proceeds, applicable Insurance Plan proceeds, and/or such benefits due to me, may not relieve me of obligations to pay the Hospital, Physicians, Care Providers, and/or their respective assignees, for charges that are not covered by this assignment.

I hereby appoint the Hospital as my Attorney-In-Fact under circumstances permitted by law (and to the extent not prohibited by an applicable provider contract) to on my behalf execute all documents and take all actions deemed necessary by the Hospital to receive its payment (and to the extent the Hospital is authorized by applicable Physicians, Care Providers, and/or their respective assignees, in accordance with applicable law, for the Hospital to procure payment respectively on their behalf) of such Program proceeds, Insurance Plan proceeds, and/or all other benefits.

This assignment of benefits and appointment of Attorney-In-Fact may not be revoked unless such revocation is required pursuant to applicable law.

I fully understand that although the Hospital, Physicians, Care Providers, and/or their respective assignees may file a claim on my behalf as a courtesy, that the same does not impose any obligation, contractual or otherwise, upon the Hospital, Physicians, Care Providers, and/or their respective assignees. To the extent permitted by law, and for the benefit of the Hospital, Physicians, Care Providers, and/or their respective assignees, as applicable, I agree to be responsible for instituting suit within the applicable statute of limitations, executing documents, taking such actions as necessary to receive payments, and/or forwarding any payments received for the Services rendered to me to the Hospital, Physicians, Care Providers, and/or their respective assignees, as applicable, when, under the following circumstances, the Hospital, Physicians, Care Providers and/or their respective assignees are not permitted by law (or are prohibited by an applicable provider contract) to: a) be assigned and transferred rights, title and interest in all benefits, liens, damages, indemnity, reinsurance or other monies payable for Services rendered to me; b) be paid directly for Services provided to me by Hospital, Physicians, Care Providers, and/or their assignees; and/or c) execute documents on my behalf in order to receive payments. I further authorize the Hospital, Physicians, Care Providers, and/or their respective assignees, to appeal any denial under my appeal rights provisions.

I fully understand and agree that, to the extent permitted by law, the Hospital, Physicians, Care Providers, and/or their respective assignees shall be entitled to seek payment of its full charges from any third-party tortfeasors and their insurers even if benefits are payable by a managed care payer on my behalf.

If assignment or direct payment is prohibited, I direct the insurer, ERISA plan or other payer to make checks or drafts jointly payable to the beneficiary or covered person and the Hospital, and to send payment to me in care of the Hospital at the Hospital's then-current address. I authorize the Hospital to open and process any such correspondence.

Even though I have assigned my rights under my Insurance Plans as applicable, I acknowledge that it is my responsibility to follow up with my Insurance Plans regarding payment if any claim related to Services is not paid within forty-five (45) days of submission. I agree to execute all documents and take all actions that the Hospital, Physicians, Care Providers, Insurance Plans and/or their respective assignees deem necessary or beneficial in order to enable the Hospital, Physicians, Care Providers and/or their respective assignees to apply for and obtain such payment.

Notwithstanding anything herein to the contrary, I acknowledge that under Florida law, if my insurance contract is subject to Florida Statute Section 627.638, my insurance contract is not permitted to prohibit direct payment of benefits to Hospital, Physicians, Care Providers and/or their respective assignees, as applicable. Also, I will execute any further written attestation of assignment of benefits to Hospital, Physicians, Care Providers and/or their respective assignees, as requested by Hospital. Further, I acknowledge, that certain Insurance Plans that have contracted with preferred providers as defined in Florida Statute Section 627.6471(1)(b) are required by Florida Statute Section 627.638 to make payments directly to such preferred providers for Services. If Hospital, Physicians, and/or Care Providers are such preferred providers, then I shall take all actions requested by the Hospital to ensure direct payment by my Insurance Plan to Hospital, Physicians, Care Providers and/or their respective assignees, as applicable, pursuant to Florida Statute Section 627.638.

5. Billing Limitation

I understand that applicable law or a contract between the applicable payer and the Hospital, Physicians, and/or Care Providers may limit or prohibit the Hospital, Physicians and/or Care Providers from invoicing or otherwise charging me for Services. The applicable sections of this Agreement which establish my responsibilities for payment for Services shall be interpreted to impose the maximum obligations permissible under such law or contractual provision.

6. Joint Liability

In consideration of the Services provided to me, Principal Obligor and I each agree to be fully financially responsible and jointly and severally liable to the Hospital, Physicians, Care Providers and/or their respective assignees as co-obligors for payment of the

Hospital Account for Services. This means that the Hospital, Physicians, Care Providers and/or their respective assignees may require me and/or the Principal Obligor to pay any and all amounts due under this Agreement. Principal Obligor and I each further agree that the Hospital, Physicians, Care Providers and/or their respective assignees may release from responsibility or modify the obligations of either me or the Principal Obligor and the unreleased obligor will remain fully liable hereunder.

7. Enforceability

If any provision of this Agreement is finally determined by a court to be unenforceable, the remainder of this Agreement shall remain in full force and effect. This Agreement shall bind the parties hereto, including newborns and the heirs, representatives, executors, administrators, successors and assigns of such parties and newborns.

8. Personal Property and Valuables: Limitations on Liability

I acknowledge that the Hospital is not responsible for the loss of or damage to my personal property and that I am solely responsible for my personal property, including but not limited to, money, eye glasses, contact lenses, dentures, etc. I acknowledge that, if the Hospital permits, I may deposit personal property with the Hospital for safe storage in accordance with the Hospital's policy.

9. Patient Rights

I acknowledge that I have been provided with a copy of the Hospital's Patient Rights information.

10. Use and Release of Information

I acknowledge that I have received a copy of the Hospital's Notice of Patient Privacy Practices, which describes the permitted uses and disclosures of my health care information related to my care by the Hospital, Physicians and Care Providers, and payment of my charges for the Services received at the Hospital and by Physicians or Care Providers. I specifically authorize the uses and disclosures of my health care information described in the Hospital's Notice of Patient Privacy Practices.

I consent to the use and release of all my health care information, including but not limited to mental health, HIV/AIDS, genetic testing, venereal disease, and tuberculosis information, for treatment, payment and health care operations, among the affiliated entities of Adventist Health System listed in the Hospital's Notice of Patient Privacy Practices, as amended from time to time.

I consent to release of my health care information, including but not limited to medical, psychiatric, substance abuse or HIV information, for medical purposes and for payment purposes to third parties including but not limited to a Program, Insurance Plans, collection agencies, employers or other organizations responsible for payment of my charges for the Services received at the Hospital and by Physicians or Care Providers, EXCEPT:

☐ _____

_____(Please specify)

☐ None _____ (Please initial)

I consent to release of the following health care information to the Hospital's institutionally related foundation for fundraising purposes: name, address and other contact information, age, gender, dates of Services, and insurance status.

I consent to the Hospital, Physicians and/or Care Providers involved in connection with my diagnosis, care and treatment (including surgical procedures) taking and reproducing pictures (regardless of medium [e.g., photograph, film, tape, etc.]) of me during my admission/clinic visits for use in association with treatment, scientific and educational purposes, and/or Hospital department functions (e.g., performance improvements, etc.).

11. Advance Directives

☐ I DO have Advance Directives

☐ I DO NOT have Advance Directives

☐ I would like the Hospital to provide me with more information regarding Advance Directives

I acknowledge that I have had an opportunity to record with the Hospital my current preferences for Advance Directives by filing a new form or a copy of my previous Advance Directive and that the Hospital and my Physicians and Care Providers are not responsible for administering Advance Directives as to which the Hospital has not been expressly and properly notified.

12. Health Information Exchange

Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Hospital for treatment, the Hospital, Physicians and/or Care Providers may get a copy of my health care information electronically through various health information exchange connections with other health care providers.

I understand I may request that my health information not be shared through electronic health information exchange by following the directions in the Hospital's Notice of Patient Privacy Practices.

13. Authorization to Release Substance Abuse Health Care Information to Affiliated Entities of Adventist Health System

I authorize the Hospital and Adventist Health System to release all of my substance abuse health care information (which includes drug and alcohol abuse information) to the hospitals, physicians and care providers who are treating me and are affiliated with (owned or operated by) Adventist Health System for my treatment, payment of the health care services I receive and health care operations activities, like quality assurance and peer review. The list of Adventist Health System affiliated entities is available in hard copy form at the front desk of any site of service or on the websites of Adventist Health System.

I understand that this authorization in Paragraph 13 may be terminated at any time, unless Adventist Health System or its affiliated hospitals, physicians and care providers have already acted in reliance on it. If not previously revoked, I understand that this authorization is effective until I die. I further understand that I may decline to sign this authorization for release of my substance abuse health care information today by checking the box below.

__ Decline

THE UNDERSIGNED MAY RECEIVE A COPY OF THIS AGREEMENT UPON REQUEST, AND CERTIFIES THAT HE OR SHE HAS READ THIS AGREEMENT AND HAS BEEN ABLE TO ASK QUESTIONS.

Printed Name of Patient	**Printed Name of Witness**
Patient's Signature & Date	**Witness' Signature & Date**
Printed Name of Legal Representative/Principal Obligor	**Legal Representative/Principal Obligor's Signature & Date**
Relationship to Patient (Self, Legal Representative, Principal Obligator, General Agent)	**Printed Name of Interpreter [if applicable]**

IF THE PATIENT IS NOT ABLE TO GIVE CONSENT AND THE PATIENT HAS AN EMERGENCY CONDITION THAT REQUIRES IMMEDIATE CARE, AS AN EMPLOYEE OF THE HOSPITAL I HAVE SIGNED THIS FORM ON BEHALF OF THE PATIENT TO ACKNOWLEDGE THE IMPLIED CONSENT OF THE PATIENT TO THE PROVISION OF THE EMERGENCY CARE BY THE HOSPITAL, THE PHYSICIANS, AND THE CARE PROVIDERS.

Printed Name of Hospital Employee	**Printed Name of Witness**
Hospital Employee's Signature & Date	**Witness' Signature & Date**

Reason Unable to Consent

IF THE PATIENT, PRINCIPAL OBLIGOR, LEGAL REPRESENTATIVE, OR GENERAL AGENT IS ONLY ABLE TO GIVE VERBAL CONSENT, AS AN EMPLOYEE OF THE HOSPITAL I HAVE SIGNED THIS FORM ON BEHALF OF THE PATIENT TO ACKNOWLEDGE THE VERBAL CONSENT BY THE PATIENT OR THE PATIENT'S PRINCIPAL OBLIGOR, LEGAL REPRESENTATIVE, OR GENERAL AGENT, TO THE PROVISION OF TREATMENT BY THE HOSPITAL, THE PHYSICIANS, AND THE CARE PROVIDERS.

Printed Name of Patient	**Reason Verbal Consent Obtained**
Printed Name of Individual Providing Verbal Consent	**Relationship to Patient (Self, Principal Obligor, Legal Representative or General Agent)**
Printed Name of Hospital Employee	**Printed Name of Witness**
Hospital Employee's Signature & Date	**Witness' Signature & Date**