Erlanger Health System's
Consent For Admission / Outpatient Treatment

I. CONSENT FOR ADMISSION/TREATMENT

I voluntarily consent to the procedures and services that may be performed for me on an inpatient or outpatient basis under the general and special instructions of my physician, and/or my physician's assistant or designee. I understand that these procedures and services may include but are not limited to emergency treatment or services, laboratory procedures, imaging services, nursing services, medical or surgical treatment or procedures, anesthesia or Erlanger Health System ("Erlanger") services. I understand that other conditions may be diagnosed which may require additional treatment. This consent includes testing for blood-borne infectious diseases, including but not limited to hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV), if a physician orders such test(s) for diagnostic purposes. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of any treatment or examinations provided by Erlanger. I acknowledge that any supplies, medical devices or other goods sold or given to me are provided "as is", and that Erlanger disclaims any express or implied warranties related thereto.

II. ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENTS

I hereby assign to Erlanger, and any practitioner providing care and treatment to me, my child, or any other person entitled to health care benefits for this admission or outpatient treatment, any and all benefits and all interest and rights for services rendered under any insurance policies, including but not limited to Medicare, Medicaid, or any reimbursement from a pre-paid health care plan. This means that Erlanger and other practitioners will be entitled to directly receive all insurance payments on my behalf. If my treatment was caused by events which result in legal action, I assign to Erlanger Health System any interest in any claims I may have to the extent necessary to fully reimburse Erlanger Health System for rendering services to me. I certify that the insurance information I provided to Erlanger is accurate in every respect, and I agree to be financially responsible for any and all charges relating to the services provided in the event the insurance information I provided is not accurate.

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Notice Regarding Potential Out-of-Network Charges

I understand that I may receive treatment or services from Erlanger-based physicians who may be out-of-network and do not have a current contract with my insurer. I understand that the physicians and other healthcare providers that may treat me at Erlanger may not be employed by Erlanger and may not participate in my insurance network. I agree to receive medical services by an out-of-network healthcare provider.
Anesthesiologists, radiologists, emergency room physicians, and pathologists are not employed by Erlanger. Services provided by those specialists, among others, will be billed separately.

Before receiving services, I should check with my insurance carrier to find out if my providers are in-network. Otherwise, I may be at risk of higher out-of-network charges.

Erlanger has a contract with the following physician groups to provide the following services:

Anesthesia Services:
Ace Anesthesiology
Phone: (423) 778-7608
www.aceanesthesia.com

Pathology Services:
Path Group
Phone: (423) 305-0227
www.pathgroup.com/resources/patient-resources/patient-service-centers

Adult Emergency Services:
Tennessee River Physicians, PLLC
Phone: 1 (888) 568-5443
www.quickpayportal.com

Children's Emergency Services:
Pediatric Emergency Medicine Associates, LLC
Phone: 678-344-1960
www.pema-llc.com

Radiology Services:
Tennessee Interventional and Imaging Associates (TIIA)
Phone: (423) 778-7234
www.tiiarad.com

Lab Services:
LabCorp
Phone: (423) 634-1162
www.labcorp.com/contact-us

If Erlanger is out-of-network with my insurance carrier, I agree to receive medical services by Erlanger and I acknowledge that I may receive a bill for the amount unpaid by my insurance company, which may be greater than the amount I would pay for services at an in-network facility.

If I am admitted to Erlanger, or have a scheduled medical procedure, I acknowledge that I will be billed for additional charges, including any out-of-network charges, if I am provided medical services by a healthcare provider that is not in-network. In particular, I should ask Erlanger if I will be provided any medical services by anesthesiologists, radiologists, emergency room physicians, or pathologists who are not in my insurance network.

I understand I may be transferred to another facility during the course of my care and treatment. If I am transferred to an out-of-network facility, I acknowledge that I may receive a bill for the amount unpaid by my insurance company, which may be greater than the amount I would pay for services at an in-network facility. I understand that Erlanger will provide information about a transfer to a facility that is in my insurance network, if the in-network facility has similar treatment available to me and will not risk my health.

By signing this form, I acknowledge I may receive a bill for up to 100 percent (100%) of billed charges for any amount unpaid by my insurer for out-of-network healthcare services.

I will receive a separate estimate/ statement of Erlanger charges for items and services in accordance with my health benefits coverage. This estimate/ statement will be provided once healthcare providers determine what treatment and services I require.

Additional Financial Agreements

I understand and agree that my account is due in full upon rendering outpatient services or upon discharge for inpatients, with allowance made for insurance coverage approved and verified prior to discharge. In consideration of the services to be rendered, the undersigned (as patient, parent, guardian, spouse, guarantor, or agent) promises to pay Erlanger's account in accordance with Erlanger's Charge Master and payment terms. In the event an overpayment is received by Erlanger for this admission or outpatient treatment, the undersigned authorize(s) application of the overpayment to any unpaid balance for which patient/undersigned is responsible.

I consent and instruct that Erlanger can obtain my credit report at its discretion at any time and at its own expense and Erlanger may only provide the report to a third party for the sole purpose of aiding in collection evaluation and efforts on behalf of Erlanger. If my account is not paid in full within 30 days of the initial bill being sent to the last address I provided Erlanger, and Erlanger has not confirmed in writing that Erlanger has agreed to an acceptable payment plan, my account may be turned over for collection at Erlanger's option. If my account is turned over to an attorney for collection, I agree to pay 33 1/3% of the balance for attorneys' fees regardless of whether filing a lawsuit is necessary to collect the balance. In addition to paying all costs incurred in filing a suit, including but not limited to filing fees, court costs, process service fees, alias summons and costs associated with post judgment proceedings including but not limited to post judgment interest and garnishment and execution fees. If my account is turned over to a collection agency I agree to pay the costs of collection in addition to the balance of the debt.

III. CONTACT

I agree that you may call me on whatever phone numbers I give Erlanger, including land lines, cell phones, Skype numbers, or anything else. The numbers I provide you may be used to communicate with me regarding my/ person for whom I am consenting's, treatment, services rendered, regarding any unpaid balance on my account, or for any other purpose.

IV. CONTINUING TREATMENT

I consent to have all the terms of this Agreement to authorize, govern and control all future treatment and financial obligations which I, or the person I am consenting for, receive in the future by Erlanger or any of its affiliates until I execute a new Consent For Admission / Outpatient Treatment.

V. SOCIAL SECURITY AND OTHER BENEFITS

I have applied, or intend to apply, for benefits under all Titles of the Social Security Act for which I may be eligible (e.g. Titles II, XVI, XVIII, XIX), as well as for any benefits that may be available to me.

VI. MEDICARE PATIENT CERTIFICATION

I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf. I understand that self-administered medications are not covered by Medicare and that I may be responsible for payment of charges relating to all self-administered medications.

VII. MEDICATION AND MEDICAL DEVICE ASSISTANCE PROGRAM

In some cases, Erlanger may be able to obtain reimbursement for some of your medications or medical devices from the companies that manufacture them. If this occurs, the charge for the medication or medical device is removed from your bill. Most of these programs require your signature on the applications for reimbursement. To avoid you or your authorized representative having to sign this application for each medication or device, Erlanger requests that you or your authorized representative allow a Pharmacy Healthcare Solutions (PHS) representative to sign these forms on your behalf. By signing this form, you or your authorized representative are appointing PHS to carry out in your name the application forms required for PHS to obtain reimbursement for your medications or medical devices from the manufacturers. The authorization to sign on your behalf will be in full force and effect from the date you or your authorized representative sign this form.

VIII. RELEASE OF INFORMATION

I understand and acknowledge that Erlanger may use protected health information (PHI) collected about me for the provision of treatment, collection of payment, and performance of hospital operations without additional consent as detailed in Erlanger's Joint Notice of Privacy Practices (NPP). I understand and acknowledge that Erlanger participates in health information exchanges with other health care facilities and providers ("Exchange Participants"). I understand that when I seek treatment from Erlanger or Exchange Participants, my health information may be shared electronically between Erlanger and Exchange Participants in order to provide care and services to me/the patient, and I authorize Erlanger to share my health information in this manner with Exchange Participants. I understand I can opt out of having my information shared with Exchange Participants by following the process in Erlanger's NPP. I also understand that my health information may include certain "Sensitive Information" such as genetic information and diagnoses or treatments for substance abuse, mental illness (excluding psychological notes) or communicable diseases (including HIV or AIDS), and that some Sensitive Information cannot be disclosed through the medical record exchange program without a separate authorization by me. I understand and acknowledge that I may request a restriction on how my information may be used/shared by contacting Erlanger's HIM department and that I can obtain more information on this upon request and from Erlanger's NPP.

IX. LEGAL RELATIONSHIP BETWEEN ERLANGER AND PHYSICIAN

I am under the care and supervision of my attending physician. It is my physician's responsibility to obtain my informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or Erlanger services rendered to me under general and special instructions of my physician. I understand that there will be a separate charge for professional services, such as physician services. I understand that Erlanger does bill for some professional fees; otherwise, the professional fees will not be included in Erlanger's bill, and I will receive a separate bill. My physician may or may not be an employee of Erlanger, and Erlanger is not responsible for the acts or omissions of any physicians not employed by Erlanger.

Additional Financial Agreements

X. RELEASE OF LIABILITY FOR PERSONAL PROPERTY

I understand and acknowledge that Erlanger does not assume the responsibility for the safekeeping of any personal property that I choose to keep on my person or in my Erlanger room during my stay, such as but not limited to, jewelry, eyeglasses, dentures or hearing aids. Personal property should not be brought into the Erlanger and I understand and agree that Erlanger shall not be liable for loss or damage to any personal property.

XI. TEACHING AND RESEARCH HOSPITAL

Erlanger is a teaching and research institution, and I understand and acknowledge that medical residents, students, and Erlanger approved observers engaged in an educational or research purpose, may be involved in or observe my care under the direct supervision of a privileged provider or staff member.

Unless required or permitted by law, it is Erlanger's policy to obtain approval by Administration before agreeing to any external disclosure of de-identified health information. Erlanger Administration agrees to obtain written authorization from me or my authorized representative prior to any external disclosure if Administration deems authorization necessary to preserve my dignity and privacy. Any medical information used or disclosed outside of Erlanger for education and training of health care professionals, including students, residents and instructors, must be de-identified and should be presented with my dignity in mind, even if I become incapacitated or deceased.

XII. VIDEO MONITORING

I understand and acknowledge that Erlanger uses video monitoring for security purposes, and for diagnosis, care and treatment of patients and that video monitoring occurs in both public and non-public areas of Erlanger including direct care areas and patient rooms. By signing below I, for myself and/or for the patient, acknowledge and agree that I and/or the patient have no expectation of privacy in such areas of Erlanger, and that Erlanger is not liable for any demands, causes of action and suits, including but not limited to claims for invasion of privacy, unreasonable search and seizure, defamation, breach of contract or any other breach of duty arising out of or related to video monitoring.

XIII. WEAPONS/EXPLOSIVES/DRUGS

I understand and agree that if the Erlanger at any time believes there may be a weapon, explosive devices, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Erlanger may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities .

XIV. PHOTOGRAPHS, SPECIMENS AND TISSUE

I authorize the Erlanger to retain, preserve, and/or use for medical documentation, scientific and/or teaching purposes any photographs, specimens and/or tissues taken as part of any procedure performed. I understand these will be properly discarded according to Erlanger policy.

XV. PROVIDER-BASED BILLING AND FACILITY FEES

I understand that I may receive treatment or services from an Erlanger provider-based clinic which results in separate billing for physician charges and facility charges. Some Erlanger clinic locations are considered outpatient departments of the hospital, also referred to as "provider-based" clinics, which is common in large health care systems. Clinics located outside of the main hospital may be considered part of the hospital even though you are being seen in a clinic setting and not actually hospitalized.

I understand my insurance benefits may apply a larger out-of-pocket amount for the facility charges, which applies to my plan's deductible/co-insurance, while the physician charge applies to my plan's co-pay. Before receiving services, I should check with my insurance carrier to understand my benefit plan.

Provider-based clinics charge facility fees to cover the higher costs of operating these departments in compliance with the requirements of the Centers for Medicare and Medicaid Services. Some services may be offered in a clinic that is not a hospital outpatient department which would not charge the facility fee. Please refer to your provider's scheduling service to determine possible alternatives.

I understand Erlanger will send me statements which include physician and facility charges for services in accordance with my health benefits coverage.

I certify that I have read and fully understand this Consent For Admission/ Outpatient Treatment ("Consent"), and I have signed this Consent knowingly, freely, and voluntarily. If signing on behalf of a minor child or another adult, I represent that I have legal authority to give consent for their treatment, and the consent of no other person is required by agreement, court order or otherwise for such treatment. I certify that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. I understand that I am personally responsible for payment for any and all items or services not covered by insurance or other third party .

Signature of Patient/Responsible Party (Relationship to Patient)	**Time**	**Date**
Erlanger Health System Representative	**Time**	**Date**
Signature of Interpreter/Provider Using Translation Services	**Time**	**Date**

ACKNOWLEGMENT OF RECEIPT OF DOCUMENTS AND CONSENT

I acknowledge that I have been offered a copy of Erlanger Health System's **Patient Bill of Rights** and **Notice of Privacy Practices**

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Initials

I have declined to receive a copy of Erlanger's Joint Notice of Privacy Practices

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Initials

I received the **Plain Language Summary of Erlanger's Financial Assistance Policy**, and I have been verbally advised about Erlanger's Financial Assistance Policy.

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Initials

I consent to my name being listed in Erlanger Health System's directory for this visit. *Choosing not to include your name in the directory means Erlanger's information desk will not acknowledge your presence as a patient, except as required by law, to anyone wishing to visit or call. Additionally, all flowers/gifts will be returned to the florist, undeliverable.*

_____
Initials

I consent to my name being provided to clergy.

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Initials

_____
Patient's Printed Name

_____ _____ _____
Signature of Patient (or Patient's Representative) Time Date