Patient Authorizations and Acknowledgements

Baptist Health System, Inc., ("Baptist Health" or "Baptist") uses an integrated electronic medical record system (the "EMR"), which is able to be accessed by, and may be shared with, other Baptist providers who may also provide you care at Baptist hospitals, Baptist physician practices (e.g.: Baptist Primary Care, Baptist Heart Specialists, etc.) and Baptist affiliated partners. Use of the integrated EMR enables Baptist providers to work together to better address your health care needs. The EMR enables Baptist Health to obtain, exchange and provide access to your medical data electronically, for Treatment, Billing and related Healthcare Operations purposes (as those terms are defined in the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations ("HIPAA")). The EMR allows Baptist providers to see a more complete picture of your health.

Notice of Privacy Practices. I acknowledge receipt of a copy of the Baptist Health Notice of Privacy Practices (the "NPP") either at this time or previously. By accepting services at Baptist Health, I authorize Baptist Health to use and disclose information from, and release copies of, my (the patient's) medical records in accordance with Baptist Health's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers. All existing confidentiality protections under HIPAA and other federal and Florida state law apply to information disclosed during telehealth consultations. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with any telehealth consultation. Telehealth consultations will not be recorded except in the rare circumstance that my provider and I mutually agree that it is necessary for my (the patient's) care.

Contact Information. If at any time, I, or a person for whom I am responsible, provide contact information (e.g., a wireless or landline telephone number, mailing address, or e-mail address) at which I may be contacted, I consent to receive communication in any manner, including, but not limited to: automated e-mails, voicemails, written statements, texts, autodialed calls and pre-recorded messages, which could result in charges to me. This contact information may be used for treatment, payment, and operations.

I understand and agree that Baptist Health may pass on this right to its respective successors, assigns, affiliates, agents, and independent contractors, including, but not limited to, servicers and collection agents.

I acknowledge that I am the authorized user of any contact information that I provide to Baptist Health and that I have permission to use this contact information from the actual current subscriber of the information. I understand that it is my responsibility to update Baptist Health with new and updated contact information and that if I fail to update this information, I will hold Baptist Health, its affiliates, and their respective officers, directors, employees and agents harmless for untimely notifications.

Insurance/Billing (Authorization and Assignment of Benefits). As a courtesy, we will file your insurance claim on your behalf. Any patient portion due (i.e., co-pay, co-insurance, self-pay) will be collected prior to your appointment unless payment arrangements have been made with a billing representative prior to your appointment.

- **Co-pay:** A pre-set amount that is your responsibility at each visit. This is a flat rate that is subject to change each time your insurance policy is renewed.
- **Co-insurance:** A percentage of the cost of your visit based on the insurance discount that applies to the type of service you are receiving until your portion of the payments reaches the amount of your deductible for that type of service. This percentage or amount may change from visit to visit, depending on the complexity of the appointment and/or the services provided.
- **Self-Pay:** When you do not have an insurance plan or your insurance plan does not cover your provider, you will be quoted a typical amount for the type of visit. This amount may change depending on the type of service provided.

To assist with timely payment, please notify Baptist Health of any changes to your insurance policy. Unresolved patient balances may be referred to a collection agency, and the patient is responsible for any additional costs incurred. Failure to make timely payments on your account may result in having additional appointments cancelled.

I give consent for this office to bill my insurance directly for services rendered. I understand that I am financially responsible for charges not covered by my insurance company. I authorize payment directly to this practice of any insurance benefits otherwise payable to me. In the event I receive payment from my insurance carrier, I agree to endorse over to Baptist Health any payment I receive for which these fees are payable. If I would like to opt out of using my insurance to pay for services, I will complete a "Request to Restrict Disclosure of PHI" form. Otherwise, I understand that Baptist providers will bill the insurance company that has been provided to them.

I authorize any holder of medical or other information about me to release to my insurance carrier, Social Security Administration, or intermediaries any information needed for this or a related Medicare claim.

Consent to Treat. I consent to examination, diagnosis, and general medical care and treatment to be performed by Baptist personnel, including providers and assistants. I further consent to the use of information or data associated with this care for quality improvement and research purposes. Also, when my blood, tissues, DNA or other biological products ("Biological Specimens") are clinically necessary to treat me, I consent to Baptist personnel collecting, creating, storing, analyzing, using, and/or sharing such Biological Specimens and the records pertaining to them.

I affirm that I am of legal age and otherwise competent to consent to medical treatment. If not, the person signing below represents that they are the parent, legal guardian, or a person who is otherwise allowed by law to consent to the examination and treatment of the patient.

If my access to care is to be provided via telehealth, my health care provider has discussed with me the potential risks, consequences and benefits of telehealth. I have had the opportunity to ask questions about any telehealth consultation. I may withhold or withdraw consent to telehealth consultation at any time without affecting the right to future care or treatment or withdrawal of any program benefits to which I or the patient would otherwise be entitled.

Release of Medical Information. I authorize Baptist to release any medical or other information necessary to process claims to my insurance carrier. This may include my diagnosis and other records generated in the course of my treatment.

A copy of your medical records may be provided to you, a family member, or any other designated individual or organization if you complete an appropriate authorization form. We may charge for your records based on current state and federal guidelines. There will not be a charge to send your records to another physician's office. As permitted by law, we may release health information about you if you are a danger to yourself or others.

Completion of Forms. Baptist Health reserves the right to charge a nominal fee for the completion of disability and/or Family Medical Leave forms.

Patient Bill of Rights. I acknowledge that a copy of Baptist Health's "Patient's Bill of Rights" is available to me.

Unaccompanied Minors. The parents (or guardians) will be responsible for full payment unless covered by a participating managed plan. A properly executed Authorization and Consent to Treat form must be on file before we can provide healthcare services or treatment to a minor patient.

Cancellation Policy. In the event you must cancel or reschedule an appointment, we require a 24-hour advanced notice. If authorized, we do attempt to make a confirmation call for an appointment, but this is a courtesy and not a guarantee. In the event we do not receive a 24-hour notice, you may be charged a cancellation/no show fee. Please make every effort to be on time for your appointment. **If you are late for your appointment, it may have to be rescheduled based on the provider's availability.** We realize that emergencies do occur, but ask that you place a call to the office and let us know. Your provider reserves the right to discharge you from the practice and cancel any additional appointments if you develop a pattern of missing appointments without giving proper notice.

I have read and understand the above policies and agree to them in full.

I acknowledge that a copy of this consent is available to me.

Signature of Patient/Patient's Legal Guardian	Printed Name	Date	Time

PATIENT AUTHORIZATIONS AND ACKNOWLEDGEMENTS

Patient Name:

Date of Birth:

Medical Record #:

Financial #: