

## Conditions of Admission and Independent Practitioner Disclosure

Thank you for choosing a UnityPoint Health (“UPH”) hospital affiliate (“we” or “us” or “the “hospital”) for your care. By signing this document, you agree, either on behalf of yourself or the person for whom you are signing this document, that we may provide medical care to you, share your health information as described below, and receive payment for services provided to you. *Please read this document carefully.* If you have questions, ask the registration staff. Unless you need emergency care, you must sign this form prior to treatment. *If you are pregnant, all the provisions in this form apply to your newborn child/children.*

### 1. GENERAL CONSENTS AND ACKNOWLEDGMENTS

#### A. Consent to Treat

- I consent to medical treatment and health-care related services that the caregivers at the hospital consider necessary or are recommending for me and that I have agreed to receive. These services may include diagnostic, therapeutic, imaging, and laboratory services.
- I understand I may need to sign another, more specific consent form before getting some types of treatment.
- I realize and accept that the practice of medicine and surgery is not an exact science and that neither the hospital nor UPH nor Independent Practitioners (discussed below) can guarantee the results of my treatments or examinations. I also understand my treatment may present risks, which may include injury or death.

#### B. Notice of Non-Employed Independent Practitioners

- I acknowledge and understand that there will be physicians, consultants, surgeons, hospital-based physicians (such as pathologists, radiologists, emergency physicians, anesthesiologists, and hospitalists), non-physician providers (such as CRNAs, nurse practitioners, and physician assistants), and surgical vendor representatives, who provide services at the hospital and who are not employees or agents of the hospital, but instead are independent medical practitioners or contractors (“Independent Practitioners”).
- I understand that these non-employed Independent Practitioners exercise their own independent medical judgment, and that they are solely responsible for the care, treatment, and services that they order, request, direct, or provide.
- I acknowledge that these non-employed Independent Practitioners are not subject to the supervision or control of the hospital, and that the employment or agency status of physicians and other providers who treat me is not relevant and will not affect my selection of the hospital for my care.

#### C. Training and Research

- I understand the mission of the hospital includes teaching and research. This means that physicians (such as “residents” or “fellows”), nurses and other healthcare professionals “in training” may be involved in my care and treatment.
- If research opportunities are applicable to me, I may be contacted to decide if I am interested in participating in the research.

#### **D. Telehealth and Electronic Communications**

I consent to the provision of medical treatment and health-care related services by remote telehealth technology and other electronic communication platforms. However, I can change my mind and may refuse services via telehealth-related technology or equipment without affecting my future care or treatment.

Telehealth services may involve the transmission of video, audio, images, and other types of data between me and a health care provider who is at a different location than mine. The health care provider will determine whether my condition is appropriate for telehealth or other electronic communications, and I understand there is no guarantee of diagnosis, treatment, or prescription of medication. I understand I may have to travel to see a health care provider in-person for diagnosis and treatment. I also understand that when I receive telehealth services or other electronic communications, delays and disruptions in treatment may occur due to equipment or technical problems. Other risks include failures in security protections resulting in a possible breach of privacy and unauthorized or unapproved access to my medical information.

#### **E. Personal Property**

I understand my personal belongings may not be secure in my room or other care areas. The safest place for my belongings is at home. I also understand I can have my valuables not essential to my care stored in the hospital safe or a similarly secure location at the hospital until my discharge. If I choose to keep my personal belongings with me, I take full responsibility for those belongings, and I release the hospital and UPH and their staff from responsibility and any liability.

#### **F. Hospital Rules**

I agree to follow all hospital rules, including the following:

- Smoking: While in the hospital, I agree not to smoke or use smoking alternatives, including vaping, e-cigarettes, juuls, or other forms of nicotine inhalation.
- Alcohol, Drugs and Weapons: I will not bring any alcoholic beverage, illegal substance or drug, weapon, or explosive device on to hospital property. I understand and agree that if the hospital at any time believes there may be of these items in my room or with my belongings, the hospital may search my room and my personal belongings located anywhere on hospital property, take any of these items, and dispose or get rid of them, including giving them to law enforcement.
- Photos and Recordings: Unless the hospital permits, I understand that I am not allowed to take pictures or make video or audio recordings of my care, other patients, hospital or UPH workforce, providers or students while receiving medical care or while on hospital property.

#### **G. My Information**

I promise that any information I provide to the hospital about myself is correct, including my name, street address, city, state, zip code, phone numbers, email, insurance information, medical history, and all other information. I agree that I am responsible for updating my contact and insurance information if it changes. I also understand that if I provide false information, the hospital may contact law enforcement.

#### **H. Photography and Recordings**

I agree that the hospital can create photographs, images, videotapes, digital or audio recordings--including having my visit recorded--that contain my health information for diagnosis, treatment, identification, education, and healthcare operations purposes. I also agree that the hospital and UPH will own the images and/or recordings.

## **I. Consent to Email and/or Text Usage**

I agree that all telephone numbers and email addresses I provide to the hospital may be used by the hospital or those acting on its behalf to communicate with me by telephone (including cell phone), email, text, or any automated or prerecorded messages. For example, I might receive by text an appointment reminder or be asked to provide feedback on my experience with the hospital's health care team. Standard text messaging rates may apply. I understand electronic communications are not confidential or secure methods of communication. I further understand there is a risk that electronic communication regarding my medical condition and treatment might be intercepted or "caught" and used for inappropriate purposes. At any time, I can reply "Stop" and opt out of receiving text messages.

## **2. HEALTH INFORMATION CONSENTS AND ACKNOWLEDGMENTS**

- J.** My health information includes diagnostic information, lab tests, medications, allergies, history and assessment, treatment plans, progress or presence in treatment, clinical notes, prescriptions, discharge summaries, benefit information, claims information, demographic information, claims payment information, and other information pertaining to my treatment or payment for my treatment.
- K.** The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a law that protects the privacy and security of my health information anywhere in the United States. In addition, there are other federal and state laws that protect "sensitive health information," including information relating to HIV/AIDS; behavioral or mental health; developmental disabilities; treatment for substance (alcohol and/or drugs) use disorder; adult or child abuse or neglect; and genetic testing and counseling.
- L.** If my consent is required by law, I agree that the hospital and its business associates may use and disclose or share my sensitive health information for treatment, payment, and hospital operations, including care coordination, and quality measurement, in the same way that HIPAA allows the hospital to use or disclose my non-sensitive health information for these purposes. More information about these purposes is described in the UnityPoint Health Affiliated Covered Entity's Notice of Privacy Practices ("NPP"). I specifically agree that the hospital may share my sensitive and non-sensitive health information to any health plan; Medicare, Medicaid, or other government program; or other payer that I identify to the hospital for purposes of obtaining payment, utilization review, and quality measurement.
- M.** If my consent is required by law, I also agree that the hospital and UPH may share, as allowed by HIPAA, my sensitive health information (1) to researchers for research purposes in accordance with law and as described in the NPP; (2) to participants in the Organized Health Care Arrangements and Accountable Care Organizations described in the NPP; and (3) to non-UPH providers and their business associates for their treatment, payment, and healthcare operations purposes. "Non-UPH" providers may include providers and their business associates participating with UPH in programs allowing for the exchange of health information between providers for purposes of treating me or coordinating my care and improving the quality of my care.
- N.** I agree that the consents and permissions as described in this Section 2 apply to all my sensitive health information in hospital's possession, including information concerning care received prior to or after the date of this form. I understand that I may withdraw my consent as described in this Section 2 by providing a written request to Medical Records. If I withdraw my consent, I understand that my withdrawal will not apply to any uses and releases of my health information already made by the hospital before I changed my consent. I understand I have the right to inspect at any time and copy any of my sensitive health information to be disclosed.

### **3. FINANCIAL CONSENTS AND ACKNOWLEDGEMENTS**

#### **O. Insurance, Health Plan, or Program Rules and Estimates**

- I understand I must (a) follow all the rules of any insurance company or program that pays for my medical bills, including government programs such as Medicare (“health insurer”) and (b) provide my insurance information to the hospital at the time of service or as soon as possible after service and as required by my insurance policy. Health insurer rules may include getting a second opinion from another healthcare provider or calling the health insurer before having medical tests or treatments. If I do not follow my health insurer’s rules, the health insurer may not pay for my health care.
- I agree that any estimates provided by the hospital for my share of the cost of my health care represent a best guess or approximation. My actual share of the cost may differ from the estimate, depending upon my actual treatment or decisions made by my health insurer.

#### **P. Payment for Services**

- If I choose to have the hospital or an Independent Practitioner bill my health insurer to pay for my treatment, I “assign” to the hospital or the Independent Practitioner my rights to receive payment from my health insurer. This means that payment will go directly to the hospital or the Independent Practitioner. For the hospital and Independent Practitioners to bill my health insurer, I agree to provide my insurance information to the hospital and understand the hospital may share the information with the Independent Practitioners.
- If I claim benefits under Medicare, I hereby certify that the information I provide in applying for payment of such benefits is correct, and I authorize the hospital to release any information needed for any related Medicare claim.
- If my health insurer does not pay for my treatment, I give the hospital permission to take reasonable steps to appeal the denial of payment and/or to file a grievance for me. For this purpose, I appoint the hospital as my authorized representative and grant the hospital limited power of attorney to receive plan coverage information and appeal any rights to payment of healthcare benefits. I agree to cooperate and provide information as needed by the hospital for any appeal.
- Even though I may assign my rights to receive payment from my health insurer, I understand and agree that the hospital may still require payment directly from me.
- If the hospital or the Independent Practitioners have a contract with my health insurer and the care is “medically necessary,” I understand that I am responsible for to pay co-insurance, deductibles, and co-pays for the medical care I receive.
- I agree to pay on time for any amounts that I owe for medical care. If I fail to pay the amounts that I owe, I agree I will pay the costs that result from trying to get payment from me, including collection fees, court fees, attorney’s fees, and other costs of collection.

#### **Q. Fair Patient Billing Act**

- I understand that I may receive separate bills from the hospital and from Independent Practitioners for services provided to me.
- If I have questions about my insurance coverage or available benefits, I understand that I should contact my health insurer or my employer. I understand that the hospital and Independent Practitioners cannot guarantee that my care will be covered by my health insurer.

#### **R. Financial Assistance**

- If I cannot pay my bill for health care, I understand that the hospital may have some financial assistance options, including free care, discounted care, or interest-free payments. I will ask the hospital’s billing office or my Independent Practitioner whether there is any help for me to pay for my care.

**NOTICE:** The hospital and UPH does not discriminate against any person on the basis of religion, sex, gender identity, sexual orientation, race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, activities, or employment.

### **Consent**

**I have read, understood, and agreed to the terms in this Conditions of Admission. I have been given the opportunity to ask questions and have no remaining questions at this time. I understand the hospital cannot honor any changes I make to this document.**

***NOTE: You will be asked to sign (or electronically sign) this document prior to your admission.***