UnityPoint Health Meriter | PARTNER OF UWHealth

Provider Based Clinics Consent for Treatment

Thank you for choosing **UnityPoint Health Meriter**. This Consent for Medical Care explains your responsibilities and provides your consent for us to provide treatment. I understand this includes and is not limited to diagnostic procedures, screening procedures, pathology services, and radiology services, which may require further specific consent to be given at a later time.

Consent to Treat

- I consent to diagnosis, medical care, and treatment that has been or may be ordered by a licensed care professional.
- I understand that all licensed healthcare professionals are responsible and liable for their own acts, orders, and omissions.
- I understand that no results of a particular examination or treatment can be guaranteed and there are risks of medical care which may include injury or death.

Research and Training

I understand that the mission of **UnityPoint Health Meriter** includes teaching and research. I am aware that some of my care may be delivered by students who are training to be healthcare providers. Medical research advances knowledge of treatments. If there are research opportunities available to me, I may be contacted to decide if I am interested in participating in the research.

Telehealth and Electronic Communications

I consent to medical treatment and health-care related services being provided by remote telehealth technology and other electronic communication platforms. Such services involve a health care provider who is at a different location than me at the time of the service, and that such services often involve the transmission of video, audio, images, and other types of data. The remote health provider will determine whether my condition is appropriate for telehealth or other electronic communications, and I understand that there is no guarantee of diagnosis, treatment, or prescription. I also understand that delays and disruptions in treatment may occur due to technical problems and problems with equipment, and that other risks include failures in security protections resulting in a possible breach of privacy and unauthorized access to my medical information.

Further, I understand that I may have to travel to see a health care provider in-person for diagnosis and treatment matters. I have the right to refuse treatment via telehealth-related technology or equipment without affecting my future care or treatment.

Results of Treatment

I understand that care, tests, and treatments may have risks. These risks can result in injury or even death. I understand that no guarantees have been made to me as to the results of diagnosis, treatments, tests or examinations.

Drug and Alcohol Tests

I understand that drug and alcohol testing might be needed to find out what is wrong and to treat me.

Notice of Independent Practitioners

- I acknowledge and understand that there will be physicians, consultants, surgeons, hospital-based physicians such as pathologists, radiologists, emergency physicians, anesthesiologists, hospitalists, and non-physician providers (CRNAs, nurse practitioners, physician assistants), and surgical vendor representatives, who provide services at **UnityPoint Health Meriter** who are not employees or agents of **UnityPoint Health Meriter**, but instead are independent medical practitioners or contractors.
- I understand that each of these providers exercises his or her own, independent medical judgment and is solely responsible for the care, treatment, and services that he or she orders, requests, directs or provides.
- I acknowledge that these practitioners are not subject to the supervision or control of **UnityPoint Health Meriter** and that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of the hospital for my care.

Patient or Patient Representatives Initials: _____

Legal Representative Relationship: _____

PATIENT LABEL

Release of Health Records for Payment

- In order to know what payments are to be made to the hospital for my care, I agree to let the hospital share information about my care and treatment with health insurance companies, health plans, other health programs that process and pay for the care and treatment given, or other companies that agree to do work for those companies, and/or workers' compensation insurance companies and/or employers, if it is a workers' compensation case.
- I agree that if I require testing for HIV/AIDS, the hospital can give testing information, but not the test results, to the insurance companies for payment.
- This release is valid until all bills are paid.

Insurance, Health Plan, or Program Rules

- I understand that I need to follow all the rules of any insurance company or program that pays for my medical bills. Rules include, but are not limited to, getting a second opinion form another healthcare provider or calling the insurance company before having tests or treatments.
- If I do not follow the rules of the insurance company or program, they may not pay for my health care.

Payment for Services

- I understand that I am responsible for all the costs associated with my medical care. I understand by signing this Consent that the hospital and the independent providers agree to bill my health plan, other insurance, Medicare, or Medicaid, on my behalf and I assign my insurance benefits to the hospital and independent providers.
- In order for the hospital and independent providers to bill my insurance, I agree to provide my insurance information to the hospital and they may share the information with my independent providers.
- If the hospital or the independent providers have a contract with my insurance and the care is "medically necessary", I understand that I am responsible for any co-insurance, deductibles and co-pays for the medical care I receive.
- If insurance does not cover my care, I am responsible for the entire cost of the medical care I received.
- I understand that I will receive a bill from the hospital and a separate bill from the independent providers for my care.
- If my insurance doesn't pay, you have my permission to appeal the denial or file a grievance for me. I will assist you with this appeal or grievance and will let you know if the insurance company notifies me of the result of the appeal or grievance.
- For the healthcare services given to me, I agree payment can go directly to the hospital. This includes all payments to be paid for my healthcare and charges for healthcare providers' services billed by the hospital. Payments may come from these sources but are not limited to primary and secondary health insurance, accident insurance, disability or loss-of-time insurance, Medicare, Medicaid and/or workers' compensation or work-related disease claims.

Fair Patient Billing Act.

- I understand that I may receive separate bills from the providers for services provided to me.
- I understand that all providers may not participate in the same insurance plans and networks. If a provider does not participate in my insurance plan, those services may be "out of network." I understand that I may have to pay more for "out of network" services. I am responsible for contacting my insurance company to find out whether the hospital or an independent provider participates in my insurance plan or network.
- If I have questions about my insurance coverage or available benefits, I should contact my insurance plan or my employer. I understand that the hospital and independent providers cannot guarantee my care will be covered by insurance.
- If I cannot pay my bill, 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 billing office or my independent provider whether there is any help for me to pay for my care.

Failure to Pay

- I agree to pay the hospital on time.
- If I fail to pay the bills for my care, I agree that I will pay the costs that are incurred in pursuing payment from me, including collection fees, court fees, attorney's fees and other costs of collection.
- If I can't pay my bill, I will ask the hospital about its plan for helping patients who cannot pay for their care.

Use of My Information.

You can use my phone numbers, mailing address and email address to contact me about my bill and amounts owed. It is okay for you to leave me a message about my account or my care using my phone number or email address I gave you, including pre-recorded messages or calls made using an auto-dialer.

Text Messaging Opt-in

- UnityPoint Health utilizes an outside vendor for appointment reminders. By providing my mobile phone, I will receive text messages for appointment reminders. At any time, I can reply "Stop" and opt out of receiving text messaging. Standard text messaging rates may apply.

Personal Property

- I understand my personal property may not be secure in my room or other care areas.
- I understand that valuable items should be left at home or I should send them home. Hospital and/or staff are not responsible for lost, stolen, or damaged personal property.

Hospital Rules

- I agree to follow all hospital rules, including, but not limited to, no smoking, no e-cigarettes, no juuls, no vaping, or other forms of nicotine inhalation.
- I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongs, the hospital may search my room and my belongings located anywhere on hospital property, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

Consent for Photographing or Other Recording

- I consent to photographs, videotapes, digital or audio recordings, and/or images of my being recorded for security purposes, and/or UnityPoint Health's healthcare operations purposes (e.g., quality improvement activities).
- I understand that the facility retains ownership rights to the images and/or recordings. I will be allowed to request access or copies of the images and/or recordings when technologically feasible unless otherwise provided by law.
- I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment, or healthcare operations purposes or otherwise permitted or required by law.
- I agree that photographs may be taken of me and used for my treatment or identification purposes.

Notice of Non-Discrimination

This hospital does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, activities, or employment.

Consent

- I have read this consent for treatment, release of information to insurance, independent medical practitioner status, and financial responsibility; and all my questions have been answered to my satisfaction.
- I agree that the information I gave you about myself is correct, including my name, street address, city state, zip code, phone numbers, email, insurance information, medical history and all other information.

Signature of Consent

Patient/Parent/Legal Representative Signature: _____

Legal Representative Relationship: _____

Patient Information Materials (Please Initial One in Each Section)

_____ Initials — I **have been given** a brochure about my Patient Rights and Responsibilities, Notice of Privacy Practices, Advance Directives, Nondiscrimination/Accessibility Notice.

_____ Initials — I **do not want** a brochure about my Patient Rights and Responsibilities, Notice of Privacy Practices, Advance Directives, Nondiscrimination/Accessibility Notice.

_____ Initials — I have been offered and **accepted** a copy of the Plain Language Summary of UnityPoint Health Financial Assistance Policy.

_____ Initials — I have been offered and **do not want** a copy of the Plain Language Summary of UnityPoint Health Financial Assistance Policy.