INITIAL PRESENTATION

❑ Inpatient ❑ Emergency Department ❑ Provider Clinic
❑ Outpatient

I give permission for such examination and treatment as the provider(s) at Memorial Hospital at Gulfport ("Memorial") consider necessary or advisable for my care and treatment. For purposes of this Consent, Memorial shall include all inpatient care, diagnostic and therapeutic services, behavioral health services, and outpatient clinic care and treatment, as well as their agents, servants, employees, staff members, providers and volunteers. I acknowledge and understand that some or all of the medical treatment I receive may be rendered by individuals who are employed by Memorial, a governmental entity which has limited sovereign immunity under the Mississippi Tort Claims Act.

I understand:

1. Examination and treatment may include diagnostic imaging, laboratory procedures, medical/surgical care, medicines, anesthesia and/or other healing measures.
2. Techniques of telemedicine may be employed to facilitate my medical care. Techniques include, but are not limited to, electronic transmission of radiographic images (*e.g.*, X-rays), remote access to laboratory results, electronic transmission of vital signs and/or remote monitoring of life support equipment. Techniques of telemedicine also include bedside video imaging of patients.
3. Unexpected situations may arise, and I now give permission, in the event I am later unavailable or unable to consent, for the provider(s) to do what is necessary to preserve my health or life.
4. If I deliver a baby during a stay at Memorial, I give permission for such examination and treatment of that baby, as the provider(s) considers necessary and advisable.
5. The practice of medicine and surgery is not an exact science. There are no guarantees of success.

CONSENT TO RECORD, FILM AND/OR PHOTOGRAPH

I understand that Memorial may make, maintain and use photographic, video, electronic/computer or audio media to document my condition or treatment for the purposes of identification, diagnosis and care. I consent and authorize Memorial to show said media internally for educational, performance improvement and related purposes. I understand that I have the right to revoke this consent and prevent/cease production of said media by providing written notice to Memorial's Health Information Management Department at 4500 13th Street, Gulfport, MS 39501.

HIV/HEPATITIS TESTING

I specifically consent to the testing of my blood for human immunodeficiency virus (also known as HIV) and/or Hepatitis B/C, if determined by my attending provider to be necessary for determining the appropriate treatment and/or treatment procedures for me, or for the protection of the provider(s) and/or any employee or agent of Memorial exposed to my bodily fluids in a manner which could transmit such diseases.

OTHER TERMS

I understand:

1. I have either received or been given an opportunity to review the Patient Rights and Responsibilities Pamphlet and Tips for Safer Health Care Pamphlet.
2. Memorial will send me a bill.
3. Each provider specialist who examines or treats me will send a separate bill.
4. I am responsible for calling my insurance company before admission. The insurance company may reduce my benefits if I do not follow its procedures. Memorial may contact my insurance company only as a courtesy.
5. If I am in a Managed Care Plan requiring approval of a primary care provider (PCP), Memorial may contact the PCP for instructions. My insurer may not pay if I receive services without approval. In this case, I may be personally responsible for all charges for these services.
6. Memorial will not deny or delay treatment for any emergency medical condition in order to contact or receive approval from my insurance company or any PCP.

INPATIENT VALUABLES RELEASE

I understand:

1. I have been given an opportunity to have my valuables and money placed in Memorial's safe.
2. I am responsible for any loss or damage to personal property that I do not place with Memorial for safekeeping.

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CONSENT TO RELEASE OF MEDICAL INFORMATION FOR PAYMENT PURPOSES

I give permission to Memorial to release to any payor information required for payment or verification of any claim related to my treatment by Memorial. Memorial can release this medical information only to the insurance company or any third party payor involved in this claim. Third party payors may be Medicare, Medicaid, CHAMPUS, CHAMPVA, automobile or other liability insurance, or any workers' compensation plan.

OUT-OF-NETWORK BILLING DISCLOSURE

HEALTH CARE SERVICES MAY BE PROVIDED BY MEMORIAL STAFF WHO ARE NOT INCLUDED IN MY HEALTH PLAN. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES AND NON-COVERED SERVICES. ALTHOUGH MEMORIAL MAY ASSIST IN DETERMINING WHETHER HEALTH CARE SERVICES WILL BE COVERED UNDER MY HEALTH PLAN, I UNDERSTAND AND ACKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO KNOW AND UNDERSTAND WHAT SERVICES ARE COVERED UNDER MY PLAN. ALSO, IF MY HEALTH INSURANCE PROVIDER OR PLAN DETERMINES THAT ANY TREATMENT I RECEIVE IS EXPERIMENTAL OR INVESTIGATIONAL, NOT MEDICALLY NECESSARY OR IS A "NON-COVERED" SERVICE OR BENEFIT FOR ANY REASON, I UNDERSTAND AND AGREE THAT I AM SOLELY RESPONSIBLE TO PAY MEMORIAL FOR THESE SERVICES.

ASSIGNMENT OF INSURANCE BENEFITS (INCLUDING MEDICARE/MEDICAID BENEFITS)

I authorize, request and assign payment directly to Memorial covering this period of treatment, and past and future treatment if related to the incident or condition giving rise to this treatment or admission, by all insurance carriers or other payors with whom I have coverage or from whom benefits are, or may become, payable to me, including settlements or judgments flowing from the incident for which I am receiving treatment. This authorization shall include all benefits specified and/or master medical benefits otherwise payable to me. Notwithstanding the foregoing, I understand and acknowledge that if I am insured and receive out-of-network services at Memorial, no Assignment of Benefits from me to my insurer shall be considered valid or binding upon Memorial. I understand and agree to be responsible for paying the balance of the charges due and owing for any out-of-network services, regardless of the amount tendered to and/or accepted by Memorial from my insurer. All information given to Memorial regarding my insurance or other benefit status is accurate and complete.

FINANCIAL AGREEMENT AND GUARANTY OF PAYMENT

In consideration of services rendered, I unconditionally guarantee that all charges connected with treatment rendered by Memorial which are not paid by an insurance or a benefit program, including but not limited to an insured or self-insured ERISA Plan, will be paid in full within sixty (60) days of final billing, regardless of the reason why such insurance or benefit program failed or refused to pay. If I do not remit full payment within that time, Memorial may refer the bill to an attorney or collection agency. If the bill is so referred, I understand and agree that I will be responsible for attorneys' fees of 33 1/3% in addition to the amount of the bill and legal interest from sixty (60) days after final billing. I understand and agree that I will be responsible for reasonable service charges incurred by Memorial as a result of check payments that are returned for insufficient funds. I understand and agree that Memorial has the right to examine credit bureau files for financial information on unpaid debts. Memorial may inform any credit bureau of any bill for care not paid within sixty (60) days of final billing.

COMMUNICATION AUTHORIZATION

I authorize Memorial, its representatives, and any billing or debt collection service working on Memorial's behalf to contact me in the following ways using information I provided: (i) on my cellular or home phone using prerecorded messages, automatic dialing devices or other computer-assisted technology, (ii) by electronic mail (email) or text messages, or (iii) by any other form of electronic communication. I understand these contacts may include things such as appointment reminders, patient campaigns/marketing, and calls about my Memorial account balances or for any account on which I am listed as guarantor. I understand I have the right to opt out of these communications at any time.

If any clause, provision or section of this Consent for Treatment and Terms and Conditions of Service shall be ruled invalid or unenforceable by any arbitrator or court of competent jurisdiction, the invalidity of such clause, provision or section shall not affect any of the remaining clauses, provisions or sections of this document, which shall be valid and enforceable to the fullest extent permitted by law.

I have read and understand <u>all</u> pages of this Consent for Treatment and Terms and Conditions of Service and agree to be bound by all its terms and provisions. I had a chance to ask questions about any portion of this document prior to signing. Any questions I had were answered to my satisfaction.

Patient or Person Legally Permitted to Sign	Date	Witness Signature	Date
_____	_____	_____	_____

If other than the patient, please print name below and indicate relationship to patient by checking the appropriate box:

_____

- ☐ Parent with Legal Custody
- ☐ Conservator/Legal Guardian/Temporary Legal Guardian
  Explain type of conservatorship/guardianship _____
  - ☐ Official documentation of conservatorship/guardianship (*e.g.*, court papers) provided
- ☐ Person with Written Authorization (*e.g.*, Durable Power of Attorney, Healthcare Power of Attorney, etc.)
  Explain type of written authorization _____
  - ☐ Documentation of written authorization provided
- ☐ Other (Relationship to Patient) _____