Employer Care
FLORIDA HOSPITAL BUSINESS SERVICES

PATIENT INFORMATION

Please Print

Reason for Visit _____

(RAZON POR LA VISITA)

PERSON BEING SEEN (INFORMACION DEL PACIENTE):

Date (Fecha): _____ **Name (Nombre):** _____
Last (Apellidos) First (Nombre) Middle Initial (inicial del segundo nombre)

Date of Birth:
(Fecha de Nacimiento): _____ **Sex (Sexo):** M ☐ F ☐ **Age (Edad):** _____
MM/DD/YY

Social Security # (Numero Social): _____ **Race (Raza):** _____ **Enthnicity:** Hispanic/Latin ☐ Not Hispanic/Latin ☐
Unknown (Desconocido) ☐

Mailing Address:
(Dirección) _____
Street (Calle) Apt. # (# Apto.) City (Ciudad) State (Estado) Country (Pais) Postal Code (Zona Postal)

Phone #:
(Numero Del Teléfono): ( ) _____ **E-Mail Address:**
(Correo Electrónico): _____

PARENT / GUARANTOR INFO IF PATIENT IS A MINOR (INFORMACIÓN DEL ENCARGADO DEL MENOR):

Relation to Minor:
(Relación a paciente): _____ **Name (Nombre):** _____
Last (Apellido) First (Nombre) Middle Initial (inicial del segundo nombre)

Date of Birth:
(Fecha de Nacimiento): _____ **Sex (Sexo):** M ☐ F ☐ **Age (Edad):** _____
MM/DD/YY

Social Security # (Numero Social): _____ **Race (Raza):** _____ **Enthnicity:** Hispanic/Latin ☐ Not Hispanic/Latin ☐
Unknown (Desconocido) ☐

Mailing Address:
(Dirección) _____
Street (Calle) Apt. # (# Apto.) City (Ciudad) State (Estado) Country (Pais) Postal Code (Zona Postal)

Phone #:
(Numero Del Teléfono): ( ) _____ **E-Mail Address:**
(Correo Electrónico): _____

NON-RESIDENT LOCAL ADDRESS (NO RESIDENTES DIRECCION LOCAL):

HOTEL NAME:
(NOMBRA DEL HOTEL) _____

ROOM NUMBER:
(NUM. DE HABITACION) _____ **HOTEL PHONE NUMBER:**
(TELEFONO LOCAL) _____

DEPARTURE DATE:
(FECHA DE REGRESO) _____ **MOBILE PHONE NUMBER:**
(TELEFONO CELULAR _____

IF TODAY'S VISIT IS RELATED TO WORKER'S COMPENSATION: (Esta visita, se relciona con compensacion para obreros):

Company Name:
(Nombre de Empresa): _____ **Company Phone #:**
(Numero de Teléfono): ( ) _____ **Ext:**

Company Address:
(Dirección): _____
Street (Calle) Apt. # (# Apto.) City (Ciudad) State (Estado) Zip (Código Postal)

Employer Contact:
(Contacto): _____ ( ) _____
Name of Contact (Nombre del Contacto) Contact Phone Number (Número del Teléfono)

Date of Injury:
(Fecha de la Lesión): _____ **Claim #:**
(Número de reclamación): _____

IF TODAY'S VISIT IS RELATED TO MEDICAL / AUTO INSURANCE: (Esta visita, esta relacionada con sitacion medica/segurode auto):

Policy Holder Name:
(Poseedor de la póliza): _____ **Sex (Sexo):** M ☐ F ☐
Last (Apellidos) First (Nombre) Middle Initial (inicial del segundo nombre)

Date of Birth:
(Fecha de Nacimiento): _____ **Social Security #:**
MM/DD/YY **(Numero Social):** _____ **Phone #:**
(Teléfono): ( ) _____

Mailing Address (Dirección): _____
Street (Calle) City (Ciudad) State (Estado) Zip (Código Postal)

Insurance Company Name:
(Nombre de Compañia de Seguro): _____ **Policy #:**
(Número de póliza): _____

Date of Accident:
(Fecha de Accidente): _____ **Claim #:**
(Número de reclamación): _____

**All returned checks are subject to a $30.00 NSF Fee

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Date of Birth (mm/dd/yyyy):_____

Address: _____ City: _____ State: _____ Zip:_____

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF WHAT: **ALL MY HEALTH INFORMATION including any information about sensitive conditions** (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM:

Employer Care - Florida Hospital Business Services *
2600 Westhall Lane, Box 300, Maitland, FL 32751 (Headquarters)
Phone: 407-200-2300, Fax: 407-200-1362

*Florida Hospital Centra Care operates multiple service locations all of which are included in the scope of this authorization

PURPOSE: To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the day I withdraw my permission.

WITHDRAWING MY PERMISSION: I can withdraw my permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.

I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].

I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

I have read both pages of this form and agree to the disclosures above from the types of sources listed.

X _____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

_____

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ☐ Parent of minor
- ☐ Guardian
- ☐ Other personal representative (explain: _____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.

Explanation of Form Florida AHCA FC4200-004
"Universal Patient Authorization for Full Disclosure of Health Information for Treatment & Quality of Care"

Laws and regulations require that some sources of personal information have a signed authorization or permission form before releasing it. Also, some laws require specific authorization for the release of information about certain conditions and from educational sources.

"Of What": includes ALL YOUR HEALTH INFORMATION, INCLUDING:

1. **All records and other information regarding your health history, treatment, hospitalization, tests, and outpatient care. This information may relate to sensitive health conditions (if any), including but not limited to:**
    a. Drug, alcohol, or substance abuse
    b. Psychological, psychiatric or other mental impairment(s) or developmental disabilities (excludes "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501)
    c. Sickle cell anemia
    d. Birth control and family planning
    e. Records which may indicate the presence of a communicable disease or noncommunicable disease; and tests for or records of HIV/AIDS or sexually transmitted diseases or tuberculosis
    f. Genetic (inherited) diseases or tests
2. **Copies of educational tests or evaluations, including Individualized Educational Programs, assessments, psychological and speech evaluations, immunizations, recorded health information (such as height, weight), and information about injuries or treatment.**
3. **Information created before or after the date of this form.**

"From Whom" includes: **All information sources** including but not limited to medical and clinical sources (hospitals, clinics, labs, pharmacies, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, Veterans Affairs health care facilities, state registries and other state programs, all educational sources that may have some of my health information (schools, records administrators, counselors, etc.), social workers, rehabilitation counselors, insurance companies, health plans, health maintenance organizations, employers, pharmacy benefit managers, worker's compensation programs, state Medicaid, Medicare and any other governmental program.

"To Whom": For those health care providers listed in the "TO WHOM" section, your permission would also include physicians, other health care providers (such as nurses) and medical staff who are involved in your medical care at that organization's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purpose(s) permitted by this form for that organization or person that you specified. Disclosure may be of health information in paper or oral form or may be through electronic interchange.

"Purpose": Your signature on this form does NOT allow health insurers to have access to your health information for the purpose of deciding to give you health insurance or pay your bills. You can make that choice in a separate form that health insurers use.

"Withdrawal" : You have the right to revoke this authorization and withdraw your permission at any time regarding any future uses. You should understand that organizations that had your permission to access your health information may copy or include your information in their own records. These organizations, in many circumstances, are not required to return any information that they were provided nor are they required to remove it from their own records.

"Re-disclosure of Information": Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. You understand that once your information is disclosed, it may be subject to lawful re-disclosure, in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

Limitations of this Form: If you want your health information shared for purposes other than for treating you or you want only a portion of your health information shared, you need to use Form Florida AHCA FC4200-005 (Universal Patient Authorization Form For Limited Disclosure of Health Information), instead of this form. Also, this form cannot be used for disclosure of psychotherapy notes. This form does not obligate your health care provider or other person/organization listed in the "From Whom" or "To Whom" section to seek out the information you specified in the "Of What" section from other sources. Also, this form does not change current obligations and rules about who pays for copies of records.

Note to recipient(s) of the information disclosed under this permission: *This information may have been disclosed to you from records protected by state and/or federal confidentiality rules (42 CFR Part 2 or 38 CFR Part 1). If so, the state and/or federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state law and/or 42 CFR Part 2 (e.g., certain medical emergencies) or 38 CFR Part 1. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient or patient with sickle cell anemia or HIV infection.*

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under 45 CFR Parts 160 and 164 ("HIPAA"); Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) §13405 ("HITECH Act"); 42 U.S. Code §290dd-2; 42 CFR Part 2; 38 U.S. Code section 7332; 38 CFR 1.475 (Veterans Affairs); 20 U.S. Code §1232g ("FERPA"); 34 CFR parts 99 and 300; Florida Statute 408.051(4) ("Universal Patient Authorization Form"); and all other Florida Statutes, the Florida Constitution, Florida regulations or administrative rules requiring patient authorization, consent or permission to release such records (including but not limited to Florida Statutes §456.057(7)(a), §395.3025(4), §394.4615(2)(a), §381.004, §397.501(7), §760.40(2), §392.65(1), §384.29(1), and §385.202(3)).

Employer Care
FLORIDA HOSPITAL BUSINESS SERVICES

ANNUAL PERSONAL HEALTH HISTORY

Name: _____ DOB: _____ Date: _____

Current Medications and Dosage (include over-the-counter medications like Tylenol and Motrin) ☐ **No Current Medications**	**Medication**	**Dosage/Frequency**
Allergies to Medication and What happens when you take this medication? ☐ **No Known Allergies**	**Medication**	**What Happens?**

*****Please put additional medications or allergies on back of this form.**

Health Maintenance: Please indicate if you have had the following testing/immunizations and if "yes" please indicate the date.

Test/immunization	Yes	No	NA	Date
Bone density screening				
Mammogram				
Pap smear				
Colonoscopy				
Eye exam (diabetics)				
Influenza Vaccine				
Pneumonia Vaccine				
Shingles vaccine				
Td or Tdap				
PSA				

Date of last Tetanus shot _____ ☐ Less than 5 years ☐ Less than 10 years ☐ Unknown ☐ Current to Date (for children)

Past Medical History: Do you have any current or past medical problems? ☐ **Yes** ☐ **No**

If yes, check all boxes below that apply.

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign Prostatic Hypertrophy (Enlarged Prostate)
- ☐ Blood Clots
- ☐ Cancer _____
- ☐ Cardiac Arrythmia
- ☐ COPD (Emphysema)
- ☐ Coronary artery disease
- ☐ Crohn's disease (Other: Use 34000006)
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated Lipids (High Cholesterol/Triglycerides)
- ☐ Gallbladder disease
- ☐ GERD(Acid Reflux)
- ☐ Headache / Migraine
- ☐ Heart attack (Use Myocardial Infarction)
- ☐ Heart Disease
- ☐ Heart Valve Disorder
- ☐ Hepatitis / Liver Disease
- ☐ Hepatitis C (Other: Use 50711007)
- ☐ Hypertension (High BP)
- ☐ Irritable bowel disease
- ☐ Osteoporosis
- ☐ Renal / Kidney disease
- ☐ Stomach ulcer disease (Other: Use 397825006)
- ☐ Seizure disorder
- ☐ Stroke (CVA)
- ☐ TB/Positive PPD (Other: Use 268376005)
- ☐ Thyroid disease
- ☐ Other _____
- ☐ Other _____

Past Surgical History: Have you ever had any surgeries? ☐ **Yes** ☐ **No** **If yes, check all boxes below that apply.**

- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arthroscopy
- ☐ Back surgery
- ☐ Blood Transfusion
- ☐ CABG (Heart Bypass)
- ☐ Cardiac Pacemaker
- ☐ Carpal tunnel release
- ☐ Cataract extraction
- ☐ Cholecystectomy (Gallbladder removal)
- ☐ Colectomy/ Colon resection
- ☐ Gastric bypass
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ LASIK
- ☐ ORIF Surgical fracture repair
- ☐ Small bowel resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Other _____

Males Only

- ☐ Prostate biopsy
- ☐ TURP (Prostate Resection)
- ☐ Vasectomy

Females Only: Medical and Surgical History

Date of Last Period:
_____/_____/_____
☐ No period yet
☐ No longer having periods

Are you pregnant? ☐ Yes ☐ No
Trying to get pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

- ☐ Bilat. tubal ligation
- ☐ Breast augmentation
- ☐ Breast reduction
- ☐ Cesarean section (Other: Use 200144004)
- ☐ D and C
- ☐ Hysterectomy-Partial
- ☐ Hysterectomy-Total
- ☐ Hysterectomy-Vaginal
- ☐ Mastectomy
- ☐ Uterine fibroid removal (Other: Use 95315005)

Your Family History: Has anyone in your immediately family (Mom/Dad/Brothers/Sisters) suffered from the following; check all boxes that apply.

- ☐ Heart Attack (Coronary Artery Disease)
- ☐ Cancer Type:_____
- ☐ Stroke (CVA)
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ **No Relevant Family History**

Social Habits: Tobacco Use **If Yes,** ☐ **Everyday** ☐ **Heavy Smoker** ☐ **Some days** ☐ **Light Smoker**
If No, ☐ **Never a Smoker** ☐ **Former Smoker**
Alcohol Use ☐ **Yes** ☐ **No**

_____ _____
Patient Signature **Date**

Current Medications and Dosage (include over-the-counter medications like Tylenol and Motrin) ☐ **No Current Medications**	**Medication**	**Dosage/Frequency**	**Medication**	**Dosage/Frequency**

Vitamins/Herbal Supplements?

Allergies to Medication and What happens when you take this medication? ☐ **No Known Allergies**	**Medication**	**What Happens?**	**Medication**	**What Happens?**

Notice of Privacy Practice Acknowledgment / Patient Rights (Florida)

Notice of Privacy Practice Acknowledgment (Florida) pertains to the patient's financial responsibilities of (the **"Patient"**) at Employer Care (the **"Clinic"**). The Patient and/or the individual signing this acknowledgement on the Patient's behalf for purposes of financial responsibility, (the **"Principal Obligator"**) hereby agree to comply with all requirements of the Clinic. For purposes of the acknowledgement "I", "me", "my" and "myself" refer to the Patient and/or the Patient's Principal Obligator, as appropriate

1. Financial Responsibility

In consideration of the Services I will receive during my treatment and/or any subsequent related treatments at the Clinic, to the extent permitted by law, I hereby obligate myself to the Clinic (**"Clinic Account for Services"** or **"Account"**), Physicians and Care Providers and agree to pay for any and all charges, expenses and fees incurred or to be incurred in relation to the provision of Services. I understand that no credit is being extended to me and that the Clinic Account for Services is immediately due and payable in _____ County, State of Florida, as set forth herein.

I authorize the Clinic to obtain credit reports with respect to my credit history from one or more credit reporting agencies at any time regarding past, current or anticipated Services, whether or not such Service did, may, or will involve credit, a Delinquent Account or an outstanding Account balance.

I UNDERSTAND THAT, TO THE EXTENT PERMITTED BY LAW, THE CLINIC MAY, BEFORE OR AFTER TREATMENT, REQUIRE A PRE-AUTHORIZATION WITH AN EXISTING CREDIT CARD up to the total amount of all estimates, charges, expenses, and fees in relation to the Services, whether I do or do not have insurance. I further acknowledge that payment in full is required for over the counter retail items and prescription medications purchased at the time of my treatment. I further understand that, to the extent permitted by law, charges for: any balance not paid by my insurance for covered Services, full balance due for non-covered Services, and co-payments and deductibles, will be applied to the credit card at the earliest time permissible under law.

IF I HAVE MEDICARE, MEDICAID OR OTHER KINDS OF GOVERNMENT INSURANCE (the **"Program"**). I understand the Program may not cover certain Services I request or that are provided to me by the Physicians or Care Providers if the agency overseeing the Program determines the Services are not reasonable and/or medically necessary or are otherwise not covered by the Program. In accordance with this Agreement and applicable law, I also understand that I may be responsible for payment of any Services I receive if such Services are determined not to be reasonable, medically necessary or are not covered by the Program. **I have received a written statement explaining my rights under the applicable Program, if required by law.**

IF I HAVE PRIVATE INSURANCE, I AGREE TO BE RESPONSIBLE FOR CO-PAYMENTS, COINSURANCE AND DEDUCTIBLE AMOUNTS required by health insurance plans (**"Insurance Plan(s)"**). In addition to my obligations as set forth in Section 3, I understand that to the maximum extent permissible under the law, I will be responsible for: all amounts not paid by my Insurance Plan, and/or all charges the Clinic could have filed with my Insurance Plan if I fail to provide coverage information in a timely manner which results in the Clinic's inability to meet its filing deadlines. It is agreed and understood that regardless of any and all assigned benefits, monies, liens and/or causes of action, I am responsible for my Account to the maximum extent permitted by law. I understand the extent of my personal liability may be limited under a contractual arrangement between the Patient's insurer and the Clinic, or applicable law.

IF I DO NOT HAVE INSURANCE, I understand that, to the extent permitted by law, paying the Clinic bill(s) for the Account is my responsibility. Except for Services required to be provided by law, I understand that the Clinic reserves the right to, before or after treatment: require proof of my ability to pay and, to the extent permitted by law, may require a deposit payment and/or pre-authorization with an existing credit card up to the total amount of all estimates, charges, expenses and fees in relation to the Services. Any deposits shall be applied to my Account.

I AM HEREBY NOTIFIED THAT, PRIOR TO THE PROVISION OF NON-EMERGENCY SERVICES, I have the right to receive (within 7 days of such request) a written good faith estimate of reasonably anticipated charges, and that actual charges may exceed such estimate. Further, I am also hereby notified that I have the right to receive a revision to the good faith estimate, upon request. I understand that I have been notified that I have the right to receive an itemized bill, upon request.

IF I CANNOT PAY MY ACCOUNT TO THE FULL EXTENT OF MY LIABILITY, representatives from the Clinic's Financial Services Office will assist me to determine if I may qualify for assistance as provided in the Clinic's discount policies.

IF I DO NOT PAY MY ACCOUNT AND/OR I AM REFERRED TO A COLLECTION AGENCY, I will pay: (a) late payment fees on the unpaid balance of the Account in an amount equal to the lesser of the maximum rate permitted by law or eighteen percent 18% per annum; and (b) all collection costs, expenses and reasonable attorney's fees.

I CERTIFY THAT I AM NOT DELINQUENT IN THE PAYMENT OF ANY AMOUNT owed to the Clinic on my behalf or on behalf of any person for whom I am legally responsible (a **"Delinquent Account"**). If I am responsible for any Delinquent Account, I have made arrangements for payment at this time.

IF PAYMENT OF THE CLINIC ACCOUNT FOR SERVICES UNDER THIS AGREEMENT RESULTS IN A CREDIT BALANCE, I give the Clinic permission to apply the credit balance to offset amounts due under other outstanding Accounts I have with the Clinic, whether current Accounts or Delinquent Accounts. If there are any credit balances related to prior agreements between me and the Clinic, I give the Clinic permission to apply such credit balances to this Account.

I FURTHER CERTIFY THAT THE MEDICAL AND FINANCIAL INFORMATION I WILL PROVIDE IN CONNECTION WITH MY TREATMENT AT THE CLINIC IS TRUE, COMPLETE AND ACCURATE IN EVERY RESPECT.

Nothing in this Agreement shall be interpreted in any way to contradict any of the requirements under Florida Statutes ss. 395.301 or 458.323, if applicable, and to the extent anything herein could be interpreted to contradict such requirements, if applicable, the applicable statute shall govern and control.

2. Authorization of Coverage and Denial of Coverage

I hereby agree that I am solely responsible for satisfying all conditions and/or procedures (regardless of whether such conditions and/or procedures are before, during or after the provision of Services), that are necessary or appropriate for authorization and/or verification of coverage by the applicable payer of Services, including but not limited to, obtaining pre-certification, pre-authorization, or second opinions. I agree that my failure to satisfy all conditions and/or procedures could result in denial or reduction of payments by the applicable payer of Services, leaving me financially responsible for the non-reimbursed portion of my bill, to the extent permitted by law. It is further agreed and understood that satisfying all conditions and/or procedures does not relieve me of any liability for the financial responsibility permitted under applicable law, for goods and Services received by me, from the Clinic, Physicians and/or Care Providers.

I understand that a payer can deny, reduce, or otherwise fail to make full payment for a Service received, or may not be liable for payment for a Service for any reason, including but not limited pursuant to a determination that: (i) the Services are not covered Services; (ii) the payer does not authorize or certify coverage for the Services; (iii) I did not follow the conditions and/or procedures for coverage of the Services, (iv) the Services are not reasonable or medically necessary; or (v) limits of benefit coverage under my plan make me ineligible to receive full or partial coverage for the Services. If I am able to appeal a denial of coverage for a Service and decide to appeal, I will inform the Clinic immediately so that the Clinic may pursue payment only in accordance with applicable law in light of such an appeal. I further understand that, to the extent required by applicable law, I will be provided with: (i) the applicable Program notification of non-coverage of Services; and (ii) an estimate of reasonably anticipated charges by the Clinic in connection with receipt of the notification of non-coverage of Services. I further acknowledge that, in accordance with Florida Statute Section 395.107, the Clinic has posted a schedule of prices charged to an uninsured patient that includes, but is not limited to, the 50 medical Services most frequently provided by the Clinic.

I understand that if a payer denies coverage for a Service because the Service is not covered by the Program or Insurance Plan (a "Non-Covered Service"), the amount charged to me for each Non-Covered Service on the applicable invoice shall be the lesser of: (i) the Clinic's usual and customary charge for each Non-Covered Service; (ii) if applicable, the amount specified in an agreement between the Clinic and the payer for such Non-Covered Service; or (iii) the amount posted pursuant to Florida Statute Section 395.107, as set forth above; or (iv) if applicable, the maximum amount the law permits the Clinic to charge for the Non-Covered Service.

3. Assignment of Benefits

I acknowledge that Services have been and/or will be rendered to me by the Clinic, Physicians and/or Care Providers, and that I may be entitled to receive payment for these Services under one or more Programs, under one or more Insurance Plans from any other payers, or arising from any claim I might assert against others because of my injuries (my **"Claim"**). In consideration of the Services rendered, or to be rendered, to me for this treatment and/or any subsequent related treatment, I hereby irrevocably assign and transfer to the Clinic, Physicians, Care Providers, and/or their respective assignees, all right, title and interest in all benefits, liens, damages, indemnity, reinsurance or other monies payable for Services rendered, including but not limited to: group medical, indemnity, self-insured or Employee Retirement Income Security Act (**"ERISA"**) benefits or coverage; PIP; uninsured/underinsured motorist; auto or homeowner insurance; and in all causes of action against any party or entity that may be responsible for payment of benefits or monies regardless of whether or not I ultimately settle my claim with a non-admission of liability provision. I hereby request, demand and authorize that, to the maximum extent permitted by law (and to the extent not prohibited by any applicable provider contract), payment of Program proceeds, applicable Insurance Plan proceeds, and/or all other benefits as to which I am or may become entitled to for Services, be paid directly to the Clinic, Physicians, Care Providers, and/or their respective assignees. I understand that assignment of such Program proceeds, applicable Insurance Plan proceeds, and/or such benefits due to me, may not relieve me of obligations to pay the Clinic, Physicians, Care Providers, and/or their respective assignees, for charges that are not covered by this assignment.

I hereby appoint the Clinic as my Attorney-In-Fact under circumstances permitted by law (and to the extent not prohibited by an applicable provider contract) to on my behalf execute all documents and take all actions deemed necessary by the Clinic to receive its payment (and to the extent the Clinic is authorized by applicable Physicians, Care Providers, and/or their respective assignees, in accordance with applicable law, for the Clinic to procure payment respectively on their behalf) of such Program proceeds, Insurance Plan proceeds, and/or all other benefits.

This assignment of benefits and appointment of Attorney-In-Fact may not be revoked unless such revocation is required pursuant to applicable law.

I fully understand that although the Clinic, Physicians, Care Providers, and/or their respective assignees may file a claim on my behalf as a courtesy, that the same does not impose any obligation, contractual or otherwise, upon the Clinic, Physicians, Care Providers, and/or their respective assignees. To the extent permitted by law, and for the benefit of the Clinic, Physicians, Care Providers, and/or their respective assignees, as applicable, I agree to be responsible for instituting suit within the applicable statute of limitations, executing documents, taking such actions as necessary to receive payments, and/or forwarding any payments received (for the Services rendered to me) to the Clinic, Physicians, Care Providers, and/or their respective assignees, as applicable, when, under the following circumstances, the Clinic, Physicians, Care Providers and/or their respective assignees are not permitted by law (or are prohibited by an applicable provider contract) to: a) be assigned and transferred rights, title and interest in all benefits, liens, damages, indemnity, reinsurance or other monies payable for Services rendered to me; b) be paid directly for Services provided to me by Clinic, Physicians, Care Providers, and/or their assignees; and/or c) execute documents on my behalf in order to receive payments. I further authorize the Clinic, Physicians, Care Providers, and/or their respective assignees, to appeal any denial under my appeal rights provisions.

I fully understand and agree that, to the extent permitted by law, the Clinic, Physicians, Care Providers, and/or their respective assignees shall be entitled to seek payment of its full charges from any third-party tortfeasors and their insurers even if benefits are payable by a managed care payer on my behalf.

If assignment or direct payment is prohibited, I direct the insurer, ERISA plan or other payer to make checks or drafts jointly payable to the beneficiary or covered person and the Clinic, and to send payment to me in care of the Clinic at the Clinic's then-current address. I authorize the Clinic to open and process any such correspondence.

Even though I have assigned my rights under my Insurance Plans, I acknowledge that it is my responsibility to follow up with my Insurance Plans regarding payment if any claim related to Services is not paid within forty-five (45) days of submission. I agree to execute all documents and take all actions permissible under law that the Clinic, Physicians, Care Providers, Insurance Plans and/or their respective assignees deem necessary or beneficial in order to enable the Clinic, Physicians, Care Providers and/or their respective assignees to apply for and obtain such payment.

Notwithstanding anything herein to the contrary, I acknowledge that under Florida law, if my insurance contract is subject to Florida Statute Section 627.638, my insurance contract is not permitted to prohibit direct payment of benefits to Clinic, Physicians, Care Providers and/or their respective assignees, as applicable. Also, I will

execute any further written attestation of assignment of benefits to Clinic, Physicians, Care Providers and/or their respective assignees, as requested by Clinic. Further, I acknowledge, that certain Insurance Plans that have contracted with preferred providers as defined in Florida Statute Section 627.6471(1)(b) are required by Florida Statute Section 627.638 to make payments directly to such preferred providers for Services. If Clinic, Physicians, and/or Care Providers are such preferred providers, then I shall take all actions requested by the Clinic to ensure direct payment by my Insurance Plan to Clinic, Physicians, Care Providers and/or their respective assignees, as applicable, pursuant to Florida Statute Section 627.638.

4. Billing Limitation

I understand that applicable law or a contract between the applicable payer and the Clinic, Physicians, and/or Care Providers may limit or prohibit the Clinic, Physicians and/or Care Providers from invoicing or otherwise charging me for Services. The applicable sections of this Agreement which establish my responsibilities for payment for Services shall be interpreted to impose the maximum obligations permissible under such law or contractual provision.

5. Joint Liability

In consideration of the Services provided to the Patient, the Patient and Principal Obligor each agree to be fully financially responsible and jointly and severally liable to the Clinic, Physicians, Care Providers and/or their respective assignees as co-obligors for payment of the Clinic Account for Services. This means that the Clinic, Physicians, Care Providers and/or their respective assignees may require me and/or the Principal Obligor to pay any and all amounts due under this Agreement. Principal Obligor and I each further agree that the Clinic, Physicians, Care Providers and/or their respective assignees may release from responsibility or modify the obligations of either me or the Principal Obligor and the unreleased obligor will remain fully liable hereunder.

6. Enforceability

If any provision of this Agreement is finally determined by a court to be unenforceable, the remainder of this Agreement shall remain in full force and effect. This Agreement shall bind the parties hereto, including newborns and the heirs, representatives, executors, administrators, successors and assigns of such parties and newborns.

7. Exposure of Clinic Personnel

If Care Providers or Physicians are exposed to my blood or other body fluids during the course of my care (an **"Exposure"**), the Clinic may request that my blood and other body fluids be tested for the Human Immunodeficiency Virus (**"HIV"**), Hepatitis, and/or other transmittable bloodborne infections (**"Bloodborne Infections"**).

8. Use and Release of Information

I acknowledge that I have received a copy of the Clinic's Notice of Patient Privacy Practices, which describes the permitted uses and disclosures of my health care information related to my care by the Clinic, Physicians and Care Providers, and payment of my charges for the Services received at the Clinic and by Physicians or Care Providers. I specifically authorize the uses and disclosures of my health care information described in the Clinic's Notice of Patient Privacy Practices.

I consent to the use and release of all my health care information, including but not limited to mental health, HIV/AIDS, genetic testing, venereal disease, and tuberculosis information, for treatment, payment and health care operations, among the affiliated entities of Adventist Health System listed in the Clinic's Notice of Patient Privacy Practices, as amended from time to time.

I consent to release of my health care information, including but not limited to medical, psychiatric, substance abuse or HIV information, for medical purposes and for payment purposes to third parties including but not limited to a Program, Insurance Plans, collection agencies, employers or other organizations responsible for payment of my charges for the Services received at the Clinic and by Physicians or Care Providers.

With the exception of withholding from release the following health care information ***(please specify below)*** purposes: name, address and other contact information, age, gender, dates of Services, and insurance status.

☐ _____
(Please specify)

☐ None _____ (Please initial)

9. Health Information Exchange

Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Clinic for treatment, the Clinic, Physicians and/or Care Providers may get a copy of my health care information electronically through various health information exchange connections with other health care providers.

I understand I may request that my health information not be shared through electronic health information exchange by following the directions in the Clinic's Notice of Patient Privacy Practices.

10. Authorization to Release Substance Abuse Health Care Information to Affiliated Entities of Adventist Health System

I authorize the Clinic and Adventist Health System to release all of my substance abuse health care information (which includes drug and alcohol abuse information) to the clinics, hospitals, physicians and care providers who are treating me and are affiliated with (owned or operated by) Adventist Health System for my treatment, payment of the health care services I receive and health care operations activities, like quality assurance and peer review. The list of Adventist Health System affiliated entities is available in hard copy from the front desk of any site of service or on the websites of Adventist Health System.

I understand that this authorization in Paragraph 10 may be terminated at any time, unless Adventist Health System or its affiliated clinics, hospitals, physicians and care providers have already acted in reliance on it. If not previously revoked, I understand that this authorization is effective until I die. I further understand that I may decline to sign this authorization for release of my substance abuse health care information today by checking the box below.

_____Decline

THE UNDERSIGNED MAY RECEIVE A COPY OF THIS AGREEMENT UPON REQUEST, AND CERTIFIES THAT HE OR SHE HAS READ THIS AGREEMENT AND HAS BEEN ABLE TO ASK QUESTIONS.

Printed Name of Patient	**Printed Name of Witness**
Patient's Signature & Date	**Witness' Signature & Date**
Printed Name of Legal Representative/Principal Obligor	**Legal Representative/Principal Obligor's Signature & Date**
Relationship to Patient (Self, Legal Representative, Principal Obligator, General Agent)	**Printed Name of Interpreter [if applicable]**

IF THE PATIENT IS NOT ABLE TO GIVE CONSENT AND THE PATIENT HAS AN EMERGENCY CONDITION THAT REQUIRES IMMEDIATE CARE, AS AN EMPLOYEE OF THE CLINC I HAVE SIGNED THIS FORM ON BEHALF OF THE PATIENT TO ACKNOWLEDGE THE IMPLIED CONSENT OF THE PATIENT TO THE PROVISION OF THE EMERGENCY CARE BY THE CLINIC, THE PHYSICIANS, AND THE CARE PROVIDERS.

Printed Name of Clinic Employee	**Printed Name of Witness**
Clinic Employee's Signature & Date	**Witness' Signature & Date**

Reason Unable to Consent

IF THE PATIENT, PRINCIPAL OBLIGOR, LEGAL REPRESENTATIVE, OR GENERAL AGENT IS ONLY ABLE TO GIVE VERBAL CONSENT, AS AN EMPLOYEE OF THE CLINIC I HAVE SIGNED THIS FORM ON BEHALF OF THE PATIENT TO ACKNOWLEDGE THE VERBAL CONSENT BY THE PATIENT OR THE PATIENT'S PRINCIPAL OBLIGOR, LEGAL REPRESENTATIVE, OR GENERAL AGENT, TO THE PROVISION OF TREATMENT BY THE CLINIC, THE PHYSICIANS, AND THE CARE PROVIDERS.

Printed Name of Patient	**Reason Verbal Consent Obtained**
Printed Name of Individual Providing Verbal Consent	**Relationship to Patient (Self, Principal Obligor, Legal Representative or General Agent)**
Printed Name of Clinic Employee	**Printed Name of Witness**
Clinic Employee's Signature & Date	**Witness' Signature & Date**

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