Saint Luke's

Consent and Agreement of Health Care Services

CONSENT FOR TREATMENT I consent to and authorize Saint Luke's entities and physicians to provide healthcare services under the general and specific instructions of members of the medical staff. At the discretion of the professional staff, I further consent to any examinations, tests or procedures that may be deemed advisable or necessary in the diagnosis and treatment. I am aware that the practice of medicine is not an exact science. I understand that no promise, guarantee or warranty has been made regarding the results of medical treatment or examination. I authorize the Entity and my physicians to take photographs, or other images, of me or parts of my body to be used in medical evaluations or education. I also authorize the use of video/audio technology (e.g. eICU, eHospitalist, eConsults and other eHealth/telemedicine services) to monitor, assess and interact with me while under the care of the Entity to be used in medical evaluations or education.

PROFESSIONAL CARE The patient is under the professional care of an attending physician who arranges for services in the care and treatment of the patient. I realize that those who provide patient care at this Entity are medical, nursing and other health care personnel in training who may be participating in patient care as part of their education.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the release of all or any part of the patients medical and accounting record which may include information relating to mental health care, communicable diseases, HIV/AIDS, and/or treatment of alcohol/drug abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges. I also authorize the Entity to release information needed for billing purposes to physicians or entities that provide services to me related to my admission to the Entity. I understand that no information that will identify me in any way will be published. I also consent to the sharing of my health information within Saint Luke's for the purposes of treatment, payment, and healthcare operations. I understand that Saint Luke's participates in various electronic health information exchanges designed to ensure my health information is available to all persons and entities providing me with care, payment for that care, or for other purposes permitted by law. This includes health information exchanges through Epic's Care Everywhere, and any other health information exchanges that Saint Luke's participates in (collectively, the "Exchanges", full listing available at saintlukeskc.org/HIE). I understand that Saint Luke's may disclose my health information to the Exchanges, and access my health information in the Exchanges, as outlined in this consent.

ASSIGNMENT OF BENEFITS I hereby assign to Saint Luke's entities and any or all physicians; all of my interest and right to the insurance benefits otherwise payable to me for this hospitalization or outpatient services arising out of any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or on my behalf. I further authorize payment of hospital benefits (including major medical) directly to the hospital, which provided care. I assign payment of physician benefits (including major medical) to the physician or organization furnishing the services or authorize such physician or organization to submit a claim for payment. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan or government plan covering said hospitalization or outpatient service and that the Entity is not responsible for precertification. I further understand that I am financially responsible for any penalties imposed by the insurance company or self-insured health plan for lack of precertification and/or any charges not covered by this assignment of benefits.

AUTHORIZATION TO FILE AN APPEAL ON PATIENT'S BEHALF I understand at times the level of care or medical necessity for services determined appropriate by my physician may differ from the opinion of my insurance company and they may deny payment of a portion of my Entity billing. To assist me in resolving this dispute, I authorize the Entity to act on my behalf to file a grievance or appeal of such denial by my insurance company in accordance with applicable law and to notify the Entity directly of the determination of such grievances or appeals.

FINANCIAL RESPONSIBILITY In consideration of the Entity and the physicians supplying or furnishing hospitalization, Entity services and physician services; I promise to pay the Entity and the physicians for such hospitalization, Entity services and physician services supplied and furnished heretofore or to be supplied and furnished to said patient. I understand that the acceptance of insurance assignments does not relieve me from any responsibility concerning payment for said services and that I am financially responsible to the Entity and physicians for the charges not covered by the policy of the insurance or self-insured health plan. I also understand, pursuant to the hospital lien statutes of this state, if my injuries were caused by the negligence or wrongful act of another, Saint Luke's may have a lien on any and all claims or rights of action I may have against the person causing my injuries, and Saint Luke's may have the right to enforce the lien for payment of services rendered rather than seek payment from my insurance or self-insured health plan. In the event of collection, the cost of collection, including reasonable attorney fees and court costs shall be included as part of the obligation due Saint Luke's entities and physicians. Any correspondence or payments regarding disputed debts, or any payments that purport to be payments in full satisfaction of the debt owed, must be sent to Saint Luke's Centralized Business Office at 901 E. 104th St., Kansas City, MO 64131.

FINANCIAL ASSISTANCE The hospital has a financial assistance policy for which you may qualify. The income guidelines are based on Federal Poverty Limits. If your income is less than the guideline for your family size, you may qualify for assistance.

PATIENT ASSISTANCE PROGRAMS: In some cases, Saint Luke's may be able to obtain reimbursement for some of your medications and/or medical devices from companies that manufacture them. In the event this occurs, the charge for the medication or medical device is removed from your bill for that hospital stay. Your signature on this form gives Saint Luke's, or agent acting on Saint Luke's behalf, permission to sign your name on the application if needed, and view and release any personal, medical, and/or financial information required by the Patient Assistance Programs in order to apply for free drug. This information will remain confidential within Saint Luke's and will be given to the drug manufacturing companies sponsoring the program.

Patient Label:

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GENERAL TERMS

Behavior Expectation: I agree that it is my responsibility to treat other patients, visitors, and staff with respect. I agree not to electronically record any direct patient care, or use my phone, tablet or device in a way that interferes with patient care. I understand that disrespectful behaviors will not be tolerated and may lead to evaluation for my discharge.

Consent to Contact: I consent to receive communications from Saint Luke's, its contractors and collection representatives. I may be contacted in regards to my relationship with Saint Luke's, including but not limited to updates related to my visits, mySaintLuke's account, my one-time passcode, about an appointment, follow-up reminder, assignment of benefits and/or financial responsibility, billing notifications, prescription reminders, and care management. Contacts may be via live agent, voicemail, prerecorded or artificial voice messages, text message, automatic telephone dialing system, e-mail, communication apps or other communication technology, to any phone, e-mail address or other contact information or means I have provided. I understand depending on my phone plan I may be charged for calls or text messages. I understand my consent to receive such calls or texts is not a condition of receiving healthcare services.

Exit agreement: I have been informed and agree that I will voluntarily exit from Saint Luke's when it is determined in the medical judgment of my physician or the Hospital's Utilization Review Committee that I no longer need to remain under care.

Release of responsibility for valuables: I understand the hospital strongly recommends that all personal belongings and valuables be sent home or placed in the hospital's security for safekeeping until discharge. I understand the hospital shall not be liable for loss or damage to any personal property I may choose to keep with me and will not replace any personal items if they are lost or stolen.

Tobacco free policy: I understand that all Saint Luke's campuses are tobacco free. I acknowledge that I may not smoke or use any tobacco products anywhere on the campus, including the parking lot or grounds of the facility. If I make the decision to go off campus to smoke or use tobacco products, I take full responsibility for my own safety. I agree not to hold the Entity or any of its employees or agents responsible if I am injured in any way because of my decision to smoke or use tobacco products. Minors will follow state and federal laws regarding smoking. This tobacco free policy applies to e-cigarettes, vaping products and other alternative tobacco and nicotine products.

Patient satisfaction survey: Saint Luke's may contact you regarding the care you received and use this information to improve the quality of care we deliver. This survey may be provided via a telephone call or by email with a link to a secure website where you may provide anonymous input. You may also receive an email from MySaintLuke's inviting you to enroll in our online patient portal, where you can securely communicate with your physician, get lab results, visit summaries, and more.

Coordination of Benefits: I certify the insurance information provided to the Saint Luke's is correct. There is no additional insurance coverage that has not been provided.

I also agree I have received or have been offered information on the topics listed below (as applicable) through signs, packets and/or brochures, which contain information about:

- Advanced Directives
- Patient Advocacy/Patient Rights/Grievance Procedure information
- Financial Assistance policy (FAP) Summary
- Notice of Privacy Practices
- Interpreter services
- Skilled Nursing Welcome Letter and Grievance Procedure

I/We hereby certify that I/we have read all parts of this Consent and Agreement and accept all terms and conditions and state that all representations made by me are true.

☐ Interpretation services utilized

_____

Print Name of Patient

_____

Signature of Patient or Authorized Representative (include Relationship to patient) Date Time

If patient is unable to sign, explain: ☐ Minor ☐ Critical nature of illness ☐ Other:_____

If the patient is unable to sign and there is no Authorized Representative available OR if consent is being obtained via telephone, two witnesses are required.

_____ _____

Signature of Witness 1 Date/Time Print Witness 1 Name

_____ _____

Signature of Witness 2 Date/Time Print Witness 2 Name

Patient Label: