Erlanger Health
Consent For Admission / Outpatient Treatment

I. CONSENT FOR ADMISSION, TREATMENT, AND/OR DISCHARGE PLAN

I voluntarily consent to the procedures and services that may be performed for me on an inpatient or outpatient basis under the general and special instructions of my physician and/or my physician's assistant or designee. I understand that these procedures and services may include, but are not limited to emergency treatment or services, laboratory procedures, imaging services, nursing services, medical or surgical treatment or procedures, anesthesia services, transport services, volunteer services, or other Erlanger Health and/or Erlanger Western Carolina Hospital (collectively "Erlanger") services. I understand that other conditions may be diagnosed that may require additional treatment. This consent includes administration of opioids or psychotropic medications, transfer by ground or air ambulance for a higher level of care, sensitive examinations, and testing for illicit substances, drugs, or blood-borne infectious diseases, including but not limited to hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV), if a physician orders such test(s) for diagnostic purposes. Additionally, I consent to receive care and treatment by interactive audio or video communications. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of any treatment or examinations provided by Erlanger. I acknowledge that any supplies, medical devices, or other goods sold or given to me are provided "as is" and that Erlanger disclaims any express or implied warranties related thereto.

Subject to any appeal rights that may have through my insurer, I voluntarily consent to an effective discharge plan that is approved and recommended for me by my physician based on my medical needs, meets my goals of care, and, if applicable, is approved by my insurer, and I agree to timely participate in and follow such discharge plan. I understand that, if I refuse to timely participate in and follow an effective discharge plan, my refusal will constitute a trespass, which may result in my removal from the facility. Additionally, I understand that my insurer may decline to pay for medical services provided to me following my refusal of an effective discharge plan, and I may be financially responsible for such medical services.

II. ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENTS

I hereby assign to Erlanger, and any practitioner providing care and treatment to me, my child, or any other person entitled to health care benefits for this admission or outpatient treatment, any and all benefits and all interest and rights for services rendered under any insurance policies, including but not limited to Medicare, Medicaid, or any reimbursement from a pre-paid health care plan. This means that Erlanger and other practitioners will be entitled to directly receive all insurance or other payments on my behalf. If my treatment was caused by events that result in legal action, I assign to Erlanger any interest in any claims I may have to the extent necessary to fully reimburse Erlanger for rendering services to me. I certify that the insurance information I provided to Erlanger is accurate in every respect, and I agree to be financially responsible for any and all charges relating to the services provided in the event the insurance information I provided is not accurate. I understand and agree that Erlanger is not required to seek reimbursement from any health share plan that I may have and that Erlanger may require me to pay all costs and expenses related to non-emergent care prior to receiving any such non-emergent care.

Erlanger will make reasonable efforts to obtain pre-authorizations and approvals for services that require pre-authorization or approval when insurance information is provided. Regardless of pre-authorizations or approvals received, some services may be excluded from coverage. I understand and agree that it is my responsibility to determine what services are covered by my insurance policy, as Erlanger does not have access to my policy with my insurance company. Additionally, I understand and agree that I am financially responsible for all charges related to services provided that my insurance company has deemed billable to the patient, regardless of whether Erlanger obtained pre-authorization or approval for such services, Erlanger was informed that pre-authorization or approval was not required, or my insurance company denied coverage.

III. CONTACT

I agree that Erlanger may call, text, and/or email me on whatever phone numbers or email addresses I give Erlanger, including land lines, cell phones, Skype numbers, or anything else. The contact information I provide may be used to communicate with me regarding my treatment, services rendered, any unpaid balance on my account, solicitations for paperless billing, registration, collections, notifications, or for any other purpose.

IV. PROVIDER-BASED BILLING AND FACILITY FEES

Some Erlanger clinic locations are considered outpatient departments that are a part of the hospital even though patients are seen in a clinic setting and not actually hospitalized (referred to as "provider-based clinics"). Treatment at such provider-based clinics results in separate billing for physician fees and facility fees. Provider-based clinics charge facility fees to cover the higher costs of operating these departments in compliance with requirements of the Centers for Medicare and Medicaid Services. Clinics that are not provider-based clinics do not charge facility fees. I understand that my insurer may apply a larger out-of-pocket charge for facility fees, which applies to my plan's deductible/coinsurance, while physician fees apply to my plan's co-pay, and Erlanger will send me statements that include physician fees and facility fees in accordance with my benefit plan. Before receiving services, I should check with my insurance carrier to understand my benefit plan. Please refer to your provider's scheduling service to determine possible alternatives.

Notice Regarding Separate and/or Potential Out-of-Network Charges

I understand that I may receive treatment or services from Erlanger-based physicians and other healthcare providers who may be out-of-network and do not have a current contract with my insurer. I understand that the physicians and other healthcare providers that may treat me at Erlanger may not be employed by Erlanger and may not participate in my insurance network. I agree to receive medical services by any such out-of-network or non-employed healthcare provider. Anesthesiologists, radiologists, emergency room physicians, and pathologists are not employed by Erlanger. Services provided by those specialists, among others, will be billed separately.

Before receiving services, I should check with my insurance carrier to find out if my providers are in-network. Otherwise, I may be at risk of higher out-of-network charges.

Erlanger has a contract with the following physician groups to provide the following services:

Anesthesia Services:
Anesthesiology Consultants Exchange, PC
Phone: (423) 778-7608
www.aceanesthesia.com

Innovative Anesthesia Solutions
Phone: (850) 516-0799
www.iasanesthesia.com

Adult Emergency Services:
Tennessee River Physicians, PLLC
Phone: (888) 568-5443
www.quickpayportal.com

Murphy Emergency Physicians, PLLC
Phone: (877) 308-6738
bill.paymentsmd.com

Children's Emergency Services:
Pediatric Emergency Medicine Associates, LLC
Phone: (678) 344-1960
www.pema-llc.com

Radiology Services:
Tennessee Interventional and Imaging Associates (TIIA)
Phone: (423) 778-7234
www.tiiarad.com

Pathology Services:
Path Group
Phone: (423) 305-0227
www.pathgroup.com/resources/patient-resources/patient-service-centers

Arcadia Pathology Network, PLLC
Phone: (800) 846-7978
Pay.instamed.com/APN

Rutherford Regional Hospital
Phone: (844) 425-0851
www.MyRutherfordRegional.com

Ambulance Services:
Prestige Patient Transport, LLC
Phone: (937) 690-6100
www.prestigepatienttransort.com

Vital Medical Transport, LLC
Phone: (901) 606-8838
10710 Dallas Hollow Rd. Suite 101
Soddy Daisy, TN 37379

Puckett EMS
Phone: (844) 597-4911
www.puckettems.com

Lifeguard Ambulance Service, LLC
d/b/a American Medical Response
Phone: (800) 913-9106
www.amr.net

Lab Services:
LabCorp
Phone: (423) 634-1162
www.labcorp.com/contact-us

Additional Financial Agreements

If Erlanger is out-of-network with my insurance carrier, I agree to receive medical services by Erlanger, and I acknowledge that I may receive a bill for the amount unpaid by my insurance company, which may be greater than the amount I would pay for services at an in-network facility.

If I am admitted to Erlanger, or have a scheduled medical procedure, I acknowledge that I will be billed for additional charges, including any out-of-network charges, if I am provided medical services by a healthcare provider that is not in-network. In particular, I should ask Erlanger if I will be provided any medical services by anesthesiologists, radiologists, emergency room physicians, or pathologists who are not in my insurance network. I understand and agree that it is my responsibility to determine whether those who are providing goods or services to me are included in my insurance network.

I understand I may be transferred to another Erlanger or other outside facility during the course of my care and treatment. If I am transferred to an out-of-network facility, I acknowledge that I may receive a bill for the amount unpaid by my insurance company, which may be greater than the amount I would pay for services at an in-network facility. I understand that Erlanger will provide information about a transfer to a facility that is in my insurance network, if the in-network facility has similar treatment available to me and will not risk my health.

By signing this form, I acknowledge I may receive a bill for up to one hundred percent (100%) of billed charges for any amount unpaid by my insurer for out-of-network healthcare services.

I will receive a separate estimate/statement of Erlanger charges for items and services in accordance with my health benefits coverage. This estimate/statement will be provided once healthcare providers determine what treatment and services I require. Any such statement may not include charges for non-employed providers.

I understand and agree that my account is due in full upon rendering outpatient services or upon discharge for inpatients, with allowance made for insurance coverage approved and verified prior to discharge. In consideration of the services to be rendered, the undersigned (as patient, parent, guardian, spouse, guarantor, or agent) promises to pay Erlanger's account in accordance with Erlanger's Charge Master and payment terms, which may require payment in advance of receipt of some services. In the event an overpayment is received by Erlanger for this admission or outpatient treatment, the undersigned authorize(s) application of the overpayment to any unpaid balance for which patient/undersigned is responsible.

I consent and instruct that Erlanger can obtain my credit report at its discretion at any time and at its own expense, and Erlanger may only provide the report to a third party for the sole purpose of aiding in screening for financial assistance, eligibility for aid programs, and collection evaluation and efforts on behalf of Erlanger. If my account is not paid in full within 30 days of the initial bill being sent to the last address I provided Erlanger, my account may be turned over for collection at Erlanger's option. If my account is turned over to an attorney for collection, I agree to pay one-third (33 1/3%) of the balance for attorneys' fees regardless of whether filing a lawsuit is necessary to collect the balance. In addition, I agree to pay all costs incurred in collecting past due amounts, which may include but are not limited to mediation costs and fees, lawsuit filing fees, attorneys' fees, court costs, process service fees, alias summons, and any costs associated with post–judgment proceedings such as post-judgment interest, garnishment, and execution fees. If my account is turned over to a collection agency, I agree to pay the costs of collection in addition to the balance of the debt.

V. CONTINUING TREATMENT

I consent to have all the terms of this agreement to authorize, govern, and control all future treatment and financial obligations that I receive in the future by Erlanger or any of its affiliates until I execute a new Consent For Admission / Outpatient Treatment.

VI. SOCIAL SECURITY AND OTHER BENEFITS

I have applied, or intend to apply, for benefits under all Titles of the Social Security Act for which I may be eligible (e.g. Titles II, XVI, XVIII, XIX), as well as for any benefits that may be available to me. I authorize any holder of medical or other information about me and/or my child(ren) to release to the Social Security Administration or its intermediaries or carriers any information needed to apply for any Social Security benefits that may be available to me and/or my child(ren).

VII. MEDICARE PATIENT CERTIFICATION

I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf. I understand that self-administered medications are not covered by Medicare and that I may be responsible for payment of charges relating to all self-administered medications.

VIII. MEDICATION AND MEDICAL DEVICE ASSISTANCE PROGRAM

In some cases, Erlanger may be able to obtain reimbursement for some of your medications or medical devices from the companies that manufacture them. If this occurs, the charge for the medication or medical device will be removed from your bill. Most of these programs require your signature on the applications for reimbursement. To avoid you or your authorized representative having to sign this application for each medication or device, Erlanger requests that you or your authorized representative allow a Pharmacy Healthcare Solutions (PHS) representative to sign these forms on your behalf. By signing this form, you or your authorized representative are appointing PHS to carry out in your name the application forms required for PHS to obtain reimbursement for your medications or medical devices from the manufacturers. The authorization to sign on your behalf will be in full force and effect from the date you or your authorized representative sign this form.

IX. RELEASE OF INFORMATION

I understand and acknowledge that Erlanger may use protected health information (PHI) and/or other information collected about me for the provision of treatment, collection of payment, and performance of hospital operations without additional consent as detailed in Erlanger's Joint Notice of Privacy Practices (NPP). I understand and acknowledge that Erlanger participates in health information exchanges with other health care facilities and providers ("Exchange Participants"). I understand that when I seek treatment from Erlanger or Exchange Participants, my health information may be shared electronically between Erlanger and Exchange Participants in order to provide care and services to me, and I authorize Erlanger to share my health information in this manner with Exchange Participants. I understand that I can opt out of having my information shared with Exchange Participants by following the process in Erlanger's NPP. I also understand that my health information may include certain "Sensitive Information" such as genetic information and diagnoses or treatments for substance abuse, mental illness (excluding psychological notes), or communicable diseases (including HIV or AIDS), and that some Sensitive Information cannot be disclosed through the medical record exchange program without a separate authorization by me.

X. LEGAL RELATIONSHIP BETWEEN ERLANGER AND PHYSICIAN

I am under the care and supervision of my attending physician. It is my physician's responsibility to obtain my informed consent, when required, for medical or surgical treatment, special diagnostic or therapeutic procedures, or Erlanger services rendered to me under general and special instructions of my physician. I understand that there will be a separate charge for professional services, such as physician services. I understand that Erlanger bills for some professional fees; otherwise, professional fees will not be included in Erlanger's bill, and I will receive a separate bill for such professional fees. My physician may or may not be an employee of Erlanger, and Erlanger is not responsible for the acts or omissions of any physicians not employed by Erlanger.

XI. RELEASE OF LIABILITY FOR PERSONAL PROPERTY

I understand and acknowledge that Erlanger does not assume responsibility for the safekeeping of any personal property that I choose to keep on my person or in my Erlanger room during my stay, including but not limited to, home medications, jewelry, eyeglasses, dentures, or hearing aids. I understand and agree that Erlanger will not be liable for theft, loss or damage to any of my personal property, and I hereby release Erlanger from my claim, damage, or cause of action related to theft, loss or damage to my personal property.

XII. TEACHING AND RESEARCH HOSPITAL

Erlanger is a teaching and research institution, and I understand and acknowledge that medical residents, students, and Erlanger-approved observers engaged in an educational or research purpose may be involved in or observe my care under the direct supervision of a privileged provider or staff member. Unless required or permitted by law, it is Erlanger's policy to obtain approval by Administration before agreeing to any external disclosure of de-identified health information. Erlanger Administration agrees to obtain written authorization from me or my authorized representative prior to any external disclosure if such authorization is required. Any medical information used or disclosed outside of Erlanger for education and training of health care professionals, including students, residents, and instructors, will be the minimum necessary and, if possible, will be de-identified and should be presented with my dignity in mind even if I become incapacitated or deceased.

XIII. VIDEO MONITORING

I understand and acknowledge that Erlanger uses video monitoring for security purposes and for diagnosis, care, and treatment of patients and that video monitoring occurs in both public and non-public areas of Erlanger, including direct care areas and patient rooms. By signing below I acknowledge and agree that I have no expectation of privacy in such areas of Erlanger and that Erlanger is not liable for any demands, causes of action, and suits, including but not limited to claims for invasion of privacy, unreasonable search and seizure, defamation, breach of contract, or any other breach of duty arising out of or related to video monitoring.

XIV. WEAPONS, EXPLOSIVES, DRUGS

I understand that weapons of any kind, explosive devices, and illegal substances or drugs are prohibited on Erlanger property. I understand and agree that, if Erlanger 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 belongings, Erlanger may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities. Further, I understand that anyone who violates this prohibition, including myself or my visitors, may be removed from Erlanger property.

XV. PHOTOGRAPHS, SPECIMENS, AND TISSUE

I authorize Erlanger to take photographs, digital imaging, and/or video of me in connection with the care and treatment provided to me at Erlanger. I further authorize Erlanger to retain, preserve, and/or use for medical documentation, scientific, and/or teaching purposes any photographs, video, specimens, and/or tissues taken as part of any procedure performed. I understand that these items will be properly discarded according to Erlanger policy and that separate written consent will be obtained if I authorize any photographs, digital imaging, and/or video taken for purposes of my care and treatment to be used for research or in external publications or for other marketing purposes; provided, however, such separate written consent is not required and will not be obtained for any activity I may conduct on www.erlanger.org or other public Erlanger websites.

XVI. NO RECORDING AND NO TOLERANCE POLICIES

I understand that Erlanger prohibits photography, audio recording, and/or video recording of clinical encounters and of Erlanger employees or other patients. I understand and agree that, if Erlanger at any time believes any recording device is being used in a prohibited manner and/or interfering with my care and treatment, Erlanger may confiscate such recording device, and the same will be returned to me upon my discharge. Additionally, I understand that Erlanger prohibits violent, aggressive, threatening, or other inappropriate behavior. I understand and agree that anyone who violates these prohibitions, including myself or my visitors, may be removed from Erlanger property.

XVII. CONFIDENTIALITY

I understand and agree that the privileged nature and confidentiality of any discussions regarding the nature or adequacy of my care and treatment are not waived by disclosing such information to me or my representatives, and such information is and shall remain privileged and confidential under the Tennessee Patient Safety and Quality Improvement Act, North Carolina Medical Review and Quality Assurance Committee Statute, Georgia Peer Review Statute, and Health Care Quality Improvement Act and may not be distributed, copied, disseminated, or used for any other purpose.

ACKNOWLEDGMENT OF RECEIPT OF DOCUMENTS AND CONSENT

Initial:

I. _____ I have been provided a copy of Erlanger's **Joint Notice of Privacy Practices.**
OR
_____ I have declined to receive a copy of Erlanger's **Joint Notice of Privacy Practices**.

II. _____ I have been provided with a copy of Erlanger's **Patient Bill of Rights.**
OR
_____ I have declined to receive a copy of Erlanger's **Patient Bill of Rights**.

III. _____ I have been provided a copy of **Your Rights and Protections Against Surprise Medical Bills (TN).**
I have been provided a copy of **Your Rights and Protections Against Surprise Medical Bills (NC).**
OR
_____ I have declined to receive a copy of **Your Rights and Protections Against Surprise Medical Bills (TN)**.
I have declined to receive a copy of **Your Rights and Protections Against Surprise Medical Bills (NC).**

IV. _____ I have been offered a copy of the **Plain Language Summary of Erlanger's Financial Assistance Policy**, and I have been verbally advised about Erlanger's Financial Assistance Policy.

INPATIENTS ONLY:

I consent to my name being listed in Erlanger's directory for this visit. Choosing not to include your name in the directory means Erlanger's information desk will not acknowledge your presence as a patient, except as required by law, to anyone wishing to visit or call. Additionally, all flowers/gifts will be returned to the florist, as undeliverable.

_____
Initials

I consent to my name being provided to clergy.

_____
Initials

I certify that I have read and fully understand this Consent For Admission/ Outpatient Treatment and Acknowledgement of Receipt of Documents and Consent ("Consent"), and I have signed this Consent knowingly, freely, and voluntarily. If signing on behalf of a minor child or another adult, I represent that I have legal authority to give consent for the patient's treatment, and the consent of no other person is required by agreement, court order, or otherwise for such treatment. I understand that there are no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. I understand that I am personally responsible for payment for any and all items or services not covered by insurance or other third party .

Date _____ Time _____

Print Patient/ Proper Representative Name _____
☐ Patient
☐ Guardian/Responsible Party

Patient/ Proper Representative Signature _____

Signed by: ☐Patient ☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Guardian ☐ Registered Domestic Partner ☐ Other

Witness to Signature _____

TRANSLATION (If necessary) - I have accurately and completely read the foregoing document to the signatory identified below in the patient's/patient representative's primary language. He/she understood all terms and conditions and acknowledged his/her agreement by signing this document in my presence.

Primary Language, if not English _____

Translation/CRYACOM ID# _____

TELEPHONE AUTHORIZATION - Authorization for the provision of hospital services was obtained by telephone from patient's proper representative, as the patient is a minor or physically/mentally incapable of giving the necessary authorization. Prior to this telephone authorization, the information outlined in this form was provided by _____ to the patient's representative.

Print Proper Representative Name _____

Relationship to Patient _____

Witness _____ Witness _____

EMERGENCY TREATMENT - It is my professional opinion that unless hospital services are provided immediately, the patient can reasonably expect to (1) have their health (or, with respect to a pregnant woman, the health of the woman or her unborn child) placed in serious jeopardy; (2) experience serious impairment to bodily functions; or (3) experience serious dysfunction of any bodily organ or part.

Signature of Physician _____ Date _____ Time _____