A. PATIENT INFORMATION	C. ENCOUNTER INFORMATION	
LAST NAME, FIRST NAME	ECD #:	MR #
	ENC #:	Person #:

ANNUAL CONSENT FOR SERVICES: This consent will be effective for one (1) year after the date it is signed at any Baptist Health South Florida affiliates/affiliated entities of which I am a patient which include, but are not limited to:

Baptist Hospital of Miami;
Miami Cancer Institute;
Doctors Hospital;
Homestead Hospital;
Mariners Hospital;
South Miami Hospital;
West Kendall Baptist Hospital;
Fishermen's Community Hospital;
Baptist Health Medical Group Offices

Baptist Outpatient Services, including Baptist Health Medical Plazas, Outpatient Centers, Diagnostic Centers, Mammography Centers, Urgent Care Centers, Express Care Centers, Endoscopy Centers, Sleep Centers, Medical Arts Surgery Centers;
Baptist Health Home Care;
Baptist Health Care and Counseling Services;

Bethesda Hospital (East & West);
Bethesda Health Outpatient Services;
Bethesda Urgent Care Centers;
Bethesda Health Comprehensive Imaging Services
Bethesda Health Physician Group Offices.

I understand I can withdraw this consent at any time by either sending an email request to PtAccessInquiries@baptisthealth.net or by calling 786-596-2853; however, this consent will not expire for services or claims processing for admissions or visits occurring while this consent was in effect.

This consent and agreement applies to any Health Services (as defined below) that I may obtain from Baptist Health providers at a Baptist Health affiliated entity hospital, hospital based clinic, outpatient facility, clinic or physician's office, and/or from the individual affiliated health care providers (physicians, allied health professionals, medical staffs) who provide Health Services at these Baptist Health affiliated entities. I understand that while this consent covering multiple Baptist Health affiliated entities and/or health care providers is being provided for purposes of administrative convenience, each of the Baptist Health affiliated entities is a separate entity, certain affiliated health care providers are independent practitioners that provide services at the Baptist Health affiliated entities, and Baptist Health South Florida does not provide any Health Services.

BAPTIST HEALTH REP. **INITIALS**

CONSENT TO TREATMENT

I consent to all medical and surgical procedures and treatment, and services that may be administered or provided to me or my child during my or my child's hospitalization or my or my child's outpatient, clinic, or office visit, and/or otherwise provided at the Baptist Health affiliated entities by health care providers, including but not limited to goods and services, emergency treatment, surgery, medical treatment, radiological examination and diagnostic procedures, laboratory procedures or tests (including tests for blood borne infectious diseases such as hepatitis or HIV) if ordered by protocol), and/or inpatient or outpatient services performed or rendered and anesthesia and/or medications that may be administered by or under the specific or general instructions of my or my child's physician(s) or surgeon(s) (collectively, the "Health Services"). In addition, I agree to abide by facility regulations designed to enhance the care and safety of their patients and/or required for their orderly operations.

PHOTOGRAPHY AND RECORDINGS

I understand that Baptist Health affiliates may take pictures, videos, or other electronic recordings or reproductions of my or my child's medical or surgical procedure(s) and condition(s) and to include such photos, videos, or other electronic recordings or reproductions in my medical records, and to the use of any non-identifiable photographs, videos, or other electronic recordings or reproductions for treatment, educational and research purposes.

BAPTIST HEALTH REP. **INITIALS**

MEDICAL EDUCATION

I understand and acknowledge that the Baptist Health affiliated entities are teaching facilities, and that my medical treatment may be observed and/or aided by residents, medical students, or other students in the course of their training as health care professionals.

BAPTIST HEALTH REP. **INITIALS**

NOTICE OF PRIVACY PRACTICE AND RELEASE OF INFORMATION

I acknowledge that I have been provided with a copy of the Baptist Health Notice of Privacy Practices describing how Baptist Health affiliated entities and health care providers may use and disclose my health information under the federal law for treatment, payment and health care operations. Provided that Baptist Health continues its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purposes and activities permitted under the federal privacy law, which are described in the Baptist Health Notice of Privacy Practices. I also authorize the Baptist Health affiliated entities and/or health care provider(s) to request, receive, use, and disclose my or my child's medical information (including, without limitation, information related to medical and prescription history, mental health, psychiatric or

A. PATIENT INFORMATION	C. ENCOUNTER INFORMATION	
LAST NAME, FIRST NAME	ECD #: ENC #:	MR # Person #:

psychological care, alcohol or substance abuse treatment, and/or laboratory procedure results (such as HIV and other test results)), as necessary to provide or coordinate treatment or care, process any claims, and secure and collect payment for any Health Services. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named Baptist Health affiliates and/or health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the Baptist Health affiliates and/or health care provider or its attorneys in order to claim such medical benefits.

ADVANCE DIRECTIVES INFORMATION -- INPATIENTS:
I acknowledge that should I be admitted, I will receive written information concerning my individual rights under Florida law to make decisions concerning my medical/health care. I understand that I have the right to execute an Advance Directive and will be provided the opportunity to do so. I understand that I am not required to execute an advance directive as a condition of receiving care at this hospital. I also acknowledge and understand that the terms of my advance directive, should I choose to execute one, will be followed by this hospital to the extent required or allowable by law.

ADVANCE DIRECTIVES INFORMATION -- OUTPATIENTS:
Based on the nature of outpatient services, where a patient's stay is short term and doesn't allow sufficient time for a physician to determine if the conditions of the Living Will have been met, as permitted by Florida Law, full care within the capabilities of the facility will be provided. If the patient insists that he/she wants resuscitative measures withheld, any treatment, test or procedure will be cancelled. Patients will be instructed to notify their physician, with the exception of any treatment test or procedure requiring the physician's presence. In these cases the referring physician will be notified and the reasons for cancellation documented in the medical record.

PERSONAL VALUABLES
I acknowledge that this facility does not accept responsibility for any personal property. I understand that this facility advises patients to send any valuables home or to inquire about securing valuables, if this service is available in the treatment setting. I accept the risk of loss or damage to any of my or my child's personal property.

_____ _____
BAPTIST HEALTH REP. **INITIALS**

INDEPENDENT PRACTITIONERS:
I recognize that certain physicians, surgeons and allied health professionals providing medical services to me or my child as a patient of a Baptist Health affiliate are private practicing physicians/professionals and not employees or agents of the Baptist Health affiliate. These private physicians/professionals include, without limitation, radiologists, anesthesiologists, pathologists, emergency room physicians, ICU physicians, neonatologists and all other physicians/professionals called in consultation or who may otherwise be involved in providing Health Services to me or my child based on their independent professional judgment. I recognize that it is the duty of the private practicing physicians/professionals, and not the duty of the Baptist Health affiliated entities, to provide medical or surgical procedures. I agree that the Baptist Health affiliated entities are discharged from any liability for the actions of the private practicing physicians/professionals.

ASSIGNMENT OF INSURANCE BENEFITS AND APPOINTMENT OF AUTHORIZED REPRESENTATIVE
I hereby assign to the above-named Baptist Health affiliates and/or health care provider(s), as my designated authorized representative, all medical benefits and/or insurance or governmental agency or program reimbursement, if any, payable to me for Health Services rendered or provided by the Baptist Health affiliates or health care providers, regardless of their managed care network or program participation status. Where MEDICARE AND MEDICAID BENEFITS are applicable, I certify that, if a Medicare beneficiary I have received the Medicare beneficiary notice "An Important Message from Medicare", and that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct, and request that these payments of authorized benefits be made directly to this facility and its affiliates, attending and consulting physicians and allied health professionals on my behalf.
I also assign and/or convey to the Baptist Health affiliates and/or health care provider(s) any legal or administrative claim or chose in action arising under any group health plan, employee benefits plan, health insurance or other insurance concerning medical expenses incurred as a result of the Health Services I receive from the Baptist Health affiliates and/or health care provider(s) (including any right to pursue legal or administrative claims or choses in action). This constitutes an express and knowing assignment of any claims under ERISA.
I intend by this assignment and designation of authorized representative to convey to the Baptist Health affiliates and/or health care provider(s) all of my rights to claim (or place a lien on) the medical benefits related to the Health Services by the Baptist Health affiliates and/or health care provider(s), including rights to any settlement, insurance or applicable legal or administrative remedies. The assignee (Baptist Health affiliates and/or health care provider(s)) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The Baptist Health affiliates and/or health care provider(s) as my assignee and my designated authorized representative may bring suit against any such party in my name at provider's expense. I further acknowledge that this assignment of benefits does not in any way relieve me of my obligation to make payment to the Baptist Health affiliates and/or health care provider(s), and that I will remain financially responsible to them until all charges are paid in full.
Unless revoked, this assignment is valid for all administrative and judicial reviews under ERISA, Medicare, Medicaid and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

A. PATIENT INFORMATION	C. ENCOUNTER INFORMATION	
LAST NAME, FIRST NAME	ECD #:	MR #
	ENC #:	Person #:

GUARANTEE OF PAYMENT

I guarantee payment of any and all charges incurred, which are either my responsibility or which are not covered or allowable by my insurance, or Medicare, if any, to the Baptist Health affiliated entities, attending and consulting physicians and allied health professionals. This includes any co-payments or deductibles, denial of payment due to lack of medical necessity or pre-certification/authorization (as may be determined by a review organization), lack of affiliation with an HMO or any other constraint imposed as a condition of my insurance coverage.

I understand and agree that Baptist Health affiliated entities, attending and consulting physicians and allied health professionals will not abide by any insurer or third party payor pricing, terms or conditions unless those pricing, terms or conditions are expressly set forth in a duly-signed agreement between Baptist Health and such insurance company or third party payor. I understand and acknowledge that if my insurer or third party payor attempts to tender any payment on my behalf or for my benefit that is not set forth in a duly-signed agreement between Baptist Health and the party tendering the payment, in no event will such payment constitute a full and complete satisfaction of my guarantee of payment hereunder and Baptist Health will pursue payment for services rendered to me in accordance with the policies expressed in this patient consent form. I understand that my agreement to guarantee payment is independent of any defined contribution health benefits plan for which I am eligible.

I understand that my payment obligation is based on Baptist Health's current charge master (or if applicable the then current fee schedule of its affiliated entities, attending and consulting physicians and allied health professionals) at the time services are rendered or such other rate of payment to which Baptist Health affiliated entities, attending and consulting physicians and allied health professionals have agreed to in a duly signed agreement with my insurance company. I understand and acknowledge the following notice pursuant to Section 673.3111, F.S.,: Any partial payment that is tendered on my behalf or for my benefit, which is intended to constitute a full settlement of my legal responsibilities hereunder, such payment and all communications relating thereto must be sent to a designated place and person, the specific of which will be given to me upon my request. I further understand that the foregoing in no manner, express or implied, constitutes any agreement by or obligation of Baptist Health to accept such partial payment on the terms and conditions upon which it is rendered.

I agree that any delay in paying the full amount of any and all amounts for which I am legally liable and any partial payments received by Baptist Health affiliated entities, attending and consulting physicians and allied health professionals towards my charges, shall not (A) constitute acceptance of any installment payment plan (unless expressly agreed to by Baptist Health in writing), (B) constitute a waiver of the right to receive payment-in-full promptly upon demand, (C) constitute an "accord and satisfaction" of my charges, regardless of any such terms or restrictions indicated on, or included with, any payments, and (D) effect a settlement or resolve an existing dispute as to amounts due and owing by me to Baptist Health.

It is further agreed that if this account is referred for collection, I will pay the costs of collection including litigation costs and reasonable trial and appellate attorney's fees. An itemized bill is available from Patient Financial Services. I understand and acknowledge that the bill I will receive may not include charges for the services provided at the Baptist Health affiliates by attending, hospital based, and consulting physicians and allied health professionals. While I understand that these individual physicians may bill my insurance company (HMO, insurance, etc.) as a courtesy, I may be billed separately by these individuals, who may or may not be contracted providers with my insurance company (if insured), and understand it is my responsibility to pay for those services provided that are my responsibility, whether or not covered by my insurance

BAPTIST HEALTH REP. **INITIALS**

FACILITY, RELATED PARTY & THIRD PARTY COMMUNICATIONS; EMAIL COMMUNICATIONS

I hereby consent to and authorize Baptist Health affiliated entities as well as any third parties acting on their behalf or for their benefit and any successors, assigns, affiliates, medical staff, employees, officers, directors and/or agents, including without limitation any of their debt collectors and/or marketers, (collectively, the "Consented-To Parties"), to make calls to, send text messages to, send facsimile machine messages and/or advertisements to, send e-mail messages or advertisements to or otherwise communicate with me and/or contact me at any telephone number, facsimile machine number or e-mail address associated with my account(s), including, without limitation, any facsimile machine number, e-mail address, telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which I am charged for the call, whether such number or e-mail address was provided by me in the past, present or future or whether such number or e-mail address was obtained by any other method whatsoever. I agree that methods of contact may include but shall not be limited to using pre-recorded or artificial voice message and/or an automatic telephone dialing system or any other telephonic, computerized or technologically enhanced equipment or devices to enable such communications as set forth above.

By providing an e-mail address above, I will be able to access the Baptist Health patient portal to obtain information about the services I received at the Baptist Health affiliated entities. I consent to the use of that e-mail by the Consented-To Parties to communicate with me and to send me information, collection notices and advertisements whether related to the services provided by the Consented-To Parties, and for all other related reasons. However, e-mail will not be used to communicate clinical information about my condition, care, or treatment with me unless I separately consent to use e-mail for that purpose. I understand that Consented-To Parties and their employees, medical staff and agents may use, save, and have access to e-mails that are sent from or to me for these and any legally permitted purposes. I also understand that e-mails may include personal information about me, that the information included may be accessed by any individual who has access to the e-mail address I have provided, and that it is my responsibility to safeguard access to that information. (Note: Any e-mail addresses provided by a parent for communication on behalf of a patient who is their minor child will no longer be used by Baptist Health after the date that child becomes an adult).

This consent and authorization shall be construed as broadly as possible under any and all applicable state and federal laws including, without limitation, 47 U.S.C. § 227. I further acknowledge, declare and state that the foregoing consent and authorization is intended to be and shall be construed to be effective retrospectively, *nunc pro tunc*, to the date of any and all covered communication(s) and shall continue until withdrawn by me in writing (or withdrawn by me in any other means that is expressly permitted by applicable federal or state law).

BAPTIST HEALTH REP. **INITIALS**

PRINT USER ID:«UserId10P» **DATE and TIME:** «PublishDTm»

A. PATIENT INFORMATION	C. ENCOUNTER INFORMATION	
LAST NAME, FIRST NAME	ECD #: ENC #:	MR # Person #:

ACKNOWLEDGEMENT, AGREEMENT, AND CONSENT

I acknowledge that I have been given an opportunity to read, ask questions about, and receive a copy of this consent form and the Patient's Bill of Rights and that I understand their contents and/or have had any of my questions answered to my satisfaction. I also agree to all of the provisions included in this consent, which I understand will be applicable to any and all Health Services that may be provided at the Baptist Health affiliated entities by health care providers for a period of one (1) year from the date signed. The terms of this consent and authorization are severable and, to the extent any portion hereof is determined to be void, voidable or violative of any applicable state or federal law, only that portion shall be stricken and the remainder of this consent and authorization shall continue to be in effect and to be fully enforceable.

PRINT NAME	DATE/TIME	SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	PERSONAL REP'S AUTHORITY TO ACT

A copy of this form is available upon request.

A. PATIENT INFORMATION	C. ENCOUNTER INFORMATION	
LAST NAME, FIRST NAME	ECD #: ENC #:	MR # Person #:

SPECIAL SEPARATE NOTICE FROM THE BAPTIST HEALTH AFFILIATED ENTITIES

(This notice is required by law. If you have any questions or concerns, please let us know before signing.)

I acknowledge that I have been given this separate written conspicuous notice by the Baptist Health Affiliated Entities that pursuant to affiliation agreements between the Baptist Health Affiliated Entities and certain State of Florida universities, some or all of the care and treatment I receive at certain Baptist Health Affiliated Entities will or may be provided by physicians, allied health professionals, or other personnel who are employees and/or agents of the boards of those universities, and liability, if any, that may arise from the care is limited as provided by law. The State of Florida universities with which the Baptist Health Affiliated Entities maintain affiliation agreements include Florida International University (FIU), University of South Florida (USF), and Florida Atlantic University (FAU), and such other State of Florida universities with which an affiliation agreement is maintained.

PRINT NAME	DATE/TIME	SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	PERSONAL REP'S AUTHORITY TO ACT