University of Miami Health System
Consent for Medical Treatment AND Conditions of Admission

PLEASE READ BOTH SIDES BEFORE SIGNING

1 CONSENT FOR MEDICAL TREATMENT

I, the undersigned, hereby consent to any and all, including emergency treatment and services, diagnostic procedures, tests, medical treatment, and hospital care required for the diagnosis of any illness or treatments by the physicians or his/her designee, medical staff, employees, residents, medical students and agents of the University of Miami Health System and/or University of Miami Medical Group, including all hospitals, clinics, and facilities (collectively referred to as the University of Miami). I understand that as part of their training, health care students may participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment, and that these students will be supervised by instructors and clinic and/or hospital staff. I recognize that the University of Miami Miller School of Medicine and all University of Miami owned and operated hospitals and clinics are part of a teaching and research facility and that my treatment and care will be observed and in some instances aided by residents or medical students in their course of training. Additionally, I consent to the use of my non-identifiable medical data and photographs for educational purposes. 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 tests, examinations, treatments, procedures or any other services rendered.

I authorize the University of Miami to retain, preserve, and use for scientific, educational, commercial, or research purposes, or dispose of as they deem fit, any specimens, tissues, or organs taken from my body during the course of treatment. I will not share in any proceeds from any product which may be developed from them.

I further consent to the University of Miami conducting blood-borne infectious disease testing, including but not limited to testing for hepatitis, Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV), if ordered by protocol. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collections of blood specimens including discomfort from the needle stick and/or slight burning, bleeding, or soreness at the puncture site. The results of this test will become part of my confidential medical record. I understand that if I test positive, my test results will be disclosed to the Florida Department of Health with information identifying me as testing positive.

ADDITIONAL PROVISION for MINORS/INCAPACITATED PATIENT

I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient or otherwise have authority to act on their behalf for health care decisions.

2 ACCESS AND RELEASE OF MEDICAL INFORMATION

By signing this form, I hereby authorize the University of Miami to access, use and release information and/or copies of my medical records as necessary for my treatment, for payment for that treatment and for the University of Miami's health care operations; including to the hospitals, physicians or other provider(s), guarantor of my accounts, or third party payors for which I have assigned benefits for my treatment and care, and, to my referring physician, or any other healthcare provider involved in my care; and as otherwise provided in the University of Miami Health System Notice of Privacy Practices.

This includes information pertaining to psychiatric and/or psychological care, mental health, alcohol and/or substance abuse, sexually transmitted diseases, AIDS, ARC, or HIV diagnosis, testing and/or treatment. This consent for access, use and release of information also includes other admissions if related to the accident or illness giving rise to this admission, medical, and other information as necessary for the operations of the University of Miami or as required to secure payment for charges incurred by me or on my behalf, including a diagnosis of my medical condition. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare and/or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. I further authorize the Department of Health and Human Services and/or Social Security Administration to release any confidential case information related to my application for government assistance requested by the University of Miami.

I acknowledge that the University of Miami maintains electronic health record systems. I authorize the University of Miami and any of my other health care providers to use the University of Miami electronic health record systems for maintaining my health records, and to share or access my health records with other health care providers. My providers may share this information with each other as needed to provide my treatment and carry out services related to my treatment. I understand that this information will be shared primarily through electronic health record systems where all of the health care providers may exchange information to provide treatment to me.

By signing this consent, I agree that University of Miami can access and use my prescription medication history and medical records from other healthcare providers and/or third party benefit payer's/service providers for treatment purposes. Such information may be included in the University of Miami's electronic health record systems.

3 HOSPITAL BASED CLINIC ACKNOWLEDGEMENT

I hereby acknowledge that during the course of my care, I may be seen in provider-based clinics (hospital clinics) and as such I may be billed by the University of Miami, hospitals, physicians, other healthcare providers and other third parties either separately or jointly. Furthermore, I hereby acknowledge that I am responsible for the payment of such billed services as they may be adjudicated by my insurer under my specific plan benefit.

Acknowledge: _____ (Initial)

PATIENT RIGHTS AND RESPONSIBILITES: I have been given the opportunity to read and ask questions about the information contained in this form, as well as Patient's Bill of Rights and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.

Acknowledge: _____ (Initial)

Date: _____/_____/_____

Time: _____ ☐ a.m. ☐ p.m.

I hereby acknowledge that I have read this form and I understand its contents and agree to all of the provisions contained herein, which I agree shall be applicable to any and all care and treatment provided by the University of Miami within one (1) year from the date signed.

Patient/Authorized Representative Signature

X _____

If not the patient, please identify your relationship to the patient by marking below:

☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Sibling
☐ Healthcare Power of Attorney ☐ Other (please specify) _____

NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES INFORMATION REQUESTED HEREIN MAY, UPON CONVICTION, BE SUBJECT TO A FINE OR IMPRISONMENT UNDER FEDERAL LAW.

Witness	**Witness Signature:**
Print name _____ Title _____	
Date: _____/_____/_____ Time: _____ ☐ a.m. ☐ p.m.	X _____
Additional Witness*	**Additional Witness Signature:**
Print name _____ Title _____	
* Required for patients unable to sign without a representative or patients who refuse to sign	X _____

Copies of this form shall be valid as an original.

4 RELEASE OF LIABILITY FOR LOSS OF PERSONAL PROPERTY

I have been advised that it is in my best interest to send my valuables home or deposit them in the hospital vault, if inpatient, for safekeeping. Accordingly I hereby release the University of Miami and the facilities in which services are rendered from liability resulting from the loss by theft or negligence of any employee of the institution or of any third party. I agree that I am responsible for any item(s) I keep with me in my possession, including, but not limited to money, clothing, eyeglasses, jewelry, dentures, or any other personal items.

5 ASSIGNMENT OF BENEFITS

In executing the assignments of benefits, I am directing the health insurance carrier or other health benefit plan providing my coverage (including, but not limited to, any employer, employer group or trust sponsored or offered plan) to pay the University of Miami directly for the services provided during this admission. In return for the services rendered and to be rendered by the University of Miami and/or hospital-based physician, I hereby irrevocably assign and transfer to the University of Miami and/or hospital-based physicians all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans for which I am entitled services or I am entitled to recover. I understand that any payment received from these policies and/or plans will be applied to the amount that I have agreed to pay for services rendered during this admission, as further described under Section 2. This assignment shall be for the purpose of granting the University of Miami and/or hospital-based physicians an independent right of recovery against my insurer or health benefit plan, but shall not be construed as an obligation of the University of Miami and/or hospital-based physicians to pursue any such right of recovery. In no event will the University of Miami and/or hospital-based physicians retain benefits in excess of the amount owed to the University of Miami and/or hospital-based physicians for the care and treatment rendered during the admission. If a third party payer (such as an insurance company or employer group or trust sponsored or offered plan) may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist the University of Miami and/or hospital-based physicians in collecting payment from any such third party payer. I hereby appoint the University of Miami and/or hospital-based physicians as my authorized representative to pursue, if it so chooses, all administrative remedies, claims and/or lawsuits on my behalf and at the University of Miami's and/or hospital-based physicians' election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for purposes of collecting any and all benefits due me for the payment of the charges referred to in section 2 above. If the University of Miami and/or hospital-based physicians elects to pursue a claim or lawsuit against a third party payer as authorized representative, I agree to execute a special power of attorney, if requested, authorizing the University of Miami and/or hospital-based physician to take all actions necessary or appropriate in pursuit of such claim or lawsuit, including allowing the University of Miami and/or hospital-based physician to bring suit against the third party payer in my name. I agree to pay over to the University of Miami and/or hospital-based physician immediately all sums recovered in any claims or lawsuit brought on my behalf by the University of Miami and/or hospital-based physicians (up to the amount of the University of Miami's and/or hospital-based physicians' charges, plus expenses and attorney's fees).

I have read and have been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the University of Miami and/or hospital-based physicians*

**Hospital-based physicians include but are not limited to" Emergency Department Physicians, Pathologists, Radiologists, Anesthesiologists, Psychiatrist, Psychologists, or other Behavioral Health Providers. These services may be rendered by independent contractors and are not part of your hospital bill. These services will be billed for separately by each physician's billing company.*

6 MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFIT

I, the undersigned, certify that the information given by me and applied under TITLE XVIII of the Social Security Act or TITLE XIX (Medicaid) is correct. I further authorize the University of Miami and any University of Miami Miller School of Medicine physician, affiliate, or staff to release to Social Security Administration or State of Florida, or its intermediaries any and all information needed to process this or any other Medicare related claim. I request and assign that payment of all authorized benefits be made on my behalf to the University of Miami, its physicians, hospitals, and other locations of service. I understand that I am personally and fully responsible for any non-covered services, denied services, health insurance deductibles, and co-insurance payments. In addition, subsequent rejection of Medicare and/or Medicaid claims, as a result of enrollment in an HMO, will constitute responsibility for payment on my part.

7 HMO/PPO/MEDIPASS MANAGED CARE PARTICIPATION

I understand that if I am a member of an HMO/PPO/MEDIPASS or other Managed Care Organization, I am responsible for obtaining the required authorizations and referrals as mandated by my Managed Care Organization to receive care from this facility and its providers. *I further acknowledge that if I choose to receive services at this facility without proper authorization from my Managed Care Organization, I will be fully responsible for payment of my bill.* I realize that it is my responsibility as the patient to know whether a service, procedure, and/or test, etc. is covered by my Managed Care Organization. (As the patient, I may contact my Managed Care Organization to appeal their decision not to authorize services.)

Acknowledge: _____ (Initial)

8 LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

Most or all of the health care professionals performing services in the hospital are independent contractors and are not University of Miami agents or employees. Independent contractors are responsible for their own actions and the University of Miami shall not be liable for the acts or omissions of any such independent contractors. I understand that physicians or other health care professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by all physicians or health care professionals participating in my care; for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that in most instances there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

I understand that I will be under the care and supervision of my attending physician and it is the responsibility of the University of Miami and its nursing staff to carry out the instructions of all physicians. It is the responsibility of my physician or surgeon to obtain my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital procedures, or hospital services rendered for me under the general and special instructions of the physician. Independent contractor physicians may hire physician assistants and nurse practitioners to assist them in the performance of medical care and diagnosis. Such physician assistants and nurse practitioners may be employed by the independent contractor physician alone, and are not employees or agents of the University of Miami.

I hereby consent to the provision of services by employed physicians, and further consent to the provision of services by independent contractor physicians and practitioners and agree to hold the independent contractor physicians and practitioners solely responsible for such care and, further, I hereby release the University of Miami from any and all liability for the acts and omissions of these independent contractor physicians and providers.

9 PRIVATE ROOM

I understand and agree that I or the party responsible for payment for hospital and medical services is responsible for any additional charges associated with the request and use of a private room.

10 WEAPONS/EXPLOSIVES/DRUGS

I understand and agree that if the University of Miami 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, the University of Miami 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 items to law enforcement authorities.

11 GUARANTOR AGREEMENT

By signing this form as Patient/Parent/Guardian or Guarantor, spouse or agent of the aforementioned parties, I hereby agree that any and all charges that arise within the treatment, past or future treatment if related to the incident or condition giving rise to this admission or service, not covered by any insurance, program, sponsorship, or other third party coverage I may have are due and payable by me prior to treatment. I hereby acknowledge that the University of Miami has agreed to bill my insurance or other third party carrier and has agreed to do so as a courtesy and the University of Miami has the right to demand payment in full from me at any time prior to full payment from any insurance carrier or third party unless it is contractually stated that I will not be billed. I hereby acknowledge that I have been told, prior to receiving treatment, that I may be billed by the University of Miami.

I further agree that if I am more than thirty (30) days late in the payment of any bill connected with this treatment, and past and future treatment if related to the incident or condition giving rise to this admission or service, a finance charge of 1.5% per month will accrue on the unpaid balance and if the delinquent account is referred to an attorney, I agree to pay the attorney fees, court costs, and collection agency fees associated with the collection process.

12 FUTURE CONTACT

I understand and agree that in order for University of Miami or any other providers associated with my care (and their business associates and vendors) to follow up with me on services rendered, or to collect any amounts I may owe or for any other business purpose, I may be contacted by telephone at any telephone number associated with my account or found by means of skip tracing methods, which includes wireless/cellular telephone numbers that could result in billable charges to me. University of Miami and associated providers (and business associates or vendors) also reserve the right to contact me by sending text messages or e−mails if and when appropriate. Other methods used to contact me may include, but are not limited to, the use of pre−recorded/artificial voice messages and use of an automatic predictive) dialing service(s), as applicable.

I ACKNOWLEDGE HAVING READ BOTH SIDES OF THIS FORM _____(Initial)