CONSENT FOR TREATMENT

JEFFERSON COMMUNITY HEALTH AND LIFE

1. **CONSENT TO MEDICAL TREATMENT**

   I hereby acknowledge that I have (or, if signing on behalf of the patient, the patient has) a condition requiring medical diagnosis and/or related care, do herby consent to such medical care, which may include (but not necessarily be limited to) routine diagnostic procedures, medical treatment, preventative treatment, medication administration, and therapy sessions(s). Such medical care or treatment may be performed by my treating practitioner, other Jefferson Community Health and Life staff physician(s), physician assistant(s), nurse practitioner(s), or other designee that may include, but are not limited to, telemedicine providers, registered nurses, licensed practical nurses, medical assistants, technicians and others whom my treating practitioner may deem necessary while I am a patient at Jefferson Community Health and Life ("JCH&L"). I acknowledge that some physicians and certain other practitioners providing services to me are private practitioners, and are not employees or agents of JCH&L, and my consent and agreement herein applies to all such services provided at JCH&L.

   I understand that I have the right to refuse treatment and that my signature below is not a consent to non-routine or non-emergent care. This consent is designed to cover all routine outpatient and inpatient care at JCH&L's Hospital or Clinic that does not require a separate consent form. In such routine cases, the requests, consent, and agreements contained herein are valid and shall apply to all repeat visits and continuing treatment and diagnosis for the same condition. In other cases, my treating practitioner may ask me to sign a form consenting to specific care, such as surgical procedures. JCH&L encourages patients to insist on any additional information necessary to make an informed decision to consent to or refuse treatment.

   I understand that the practice of medicine is not an exact science. I acknowledge that no guarantees about results of treatments or of examinations have been made to me by JCH&L practitioners or staff.

2. **PRESERVATION OF TISSUE**

   I authorize JCH&L to retain, preserve, and/or to dispose of at its convenience, any specimens or tissues taken from my body during my visit.

3. **CONSENT FOR INFECTIOUS DISEASE TESTING**

   As a consent to treatment, but ONLY in the event of a direct exposure of my blood or bodily fluids to a JCH&L health care worker, I consent to have my blood drawn at JCH&Ls expense to test for infectious diseases.

4. **CONSENT FOR TELEHEALTH**

   I hereby consent to the use of telehealth services ordered by my treating practitioner. I understand that the consulting provider will be at a different location from me. I can decline telehealth services at any time without affecting or taking away either my right to future care/treatment, or any program benefits to which I would otherwise be entitled. If I decline the telehealth service, alternatives will be discussed including but not limited to transfer to another facility. JCH&L personnel will use real time video to transmit or share with the telemedicine provider necessary details of my medical history, examinations, x-rays, tests, photographs or other images. All existing confidentiality protections shall apply to the telehealth consultation. I will have access to all medical information resulting from the telehealth consultation as provided by law for patient access to medical records.

Dissemination of any patient identifiable images or information resulting from the telehealth consultation to researchers or other entities shall not occur without my written consent.

5. **NOTICE OF MEDICAL PRACTITIONER ON-SITE**.
JCH&L does not have a practitioner present in the Hospital 24 hours per day, 7 days per week. In the event I am admitted as an inpatient, observation patient, or outpatient surgery patient, I understand that JCH&L has available on-call a physician or an advanced practice provider serving the Hospital to meet my medical needs. Although these practitioners are not in-house all of the time, they are readily available to meet my health care needs in accordance with federal regulations.

6. **ADVANCE INSTRUCTIONS FOR HEALTH CARE**
I understand that I may indicate in writing, by an Advance Directive (i.e., Living Will or Durable Power of Attorney for Health Care), my desire to receive, select and/or define medical or surgical treatment or choose non-treatment. If my Advance Directive is provided to JCH&L, a copy will be placed with my medical records, and JCH&L will recognize such instructions consistent with its policies.

7. **RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES**
JCH&L will assume NO RESPONSIBILITY for any loss or damage to any personal property. I understand that I am encouraged to safeguard such items at home. Small valuable items may be placed in the Hospital's safe, by contacting my nurse. **I, the patient/responsible party, accept full responsibility for loss or damage of personal items while at the Hospital or Clinic.**

8. **PRE-ADMISSION CERTIFICATION/AUTHORIZATION FOR INSURANCE**
It is my responsibility to obtain pre-admission certification/authorization and/or provide notification of admission as required by my insurance carrier. Not obtaining required certifications/authorizations may mean that my insurance carrier will not cover services that I receive. In such a case, I understand that I will be responsible personally for the cost of such services provided to me.

9. **INSURANCE INFORMATION; DISCLOSURES FOR PAYMENT PURPOSES**
I certify that the insurance information given by me is correct. I understand that it is my responsibility to notify JCH&L of any insurance coverage changes. If I do not have insurance information I will be marked as private pay unless and until my insurance information is provided. JCH&L may release my health care to any person or entity liable for payment on my behalf in order to verify coverage or payment questions or for any other purpose related to benefit payment.

10. **FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS**
I agree to promptly and fully pay Jefferson Community Health and Life for services and supplies provided to me at the rates now in effect or to become effective during the course of my treatment. I hereby personally obligate myself (and the patient, if I am not the patient) for payment of all charges to the extent not covered by insurance, or those charges not promptly paid by insurance. I understand that I may be asked for my copay amount or a specified amount at check-in. Furthermore, any patient responsibility amounts owed by me are due upon my receipt of a summary statement. I agree, subject to state or federal law, to pay all costs, reasonable attorney fees, expenses, delinquent charges and interest, in the event JCH&L has to take action to collect the same because of my failure to pay in full. I authorize JCH&L to obtain one or more credit reports on the patient and/or me. No extension or forbearance, no attempt to obtain payment from insurance or other sources and no delay or lack of diligence in collecting such charges shall waive or release the personal financial obligations hereunder. I

understand that financial assistance is available, and a copy of the financial assistance policy is available upon request.

I hereby assign to JCH&L, for services provided by JCH&L and its employees or others working under contract or arrangement with JCH&L, all coverage or other benefits under any governmental or private insurance policy, plan or program. I direct that all such benefits be paid directly to JCH&L. For private physicians billing separately from JCH&L, I assign coverage and benefits, and direct payment for their services provided to me, to such physicians. If there is an overpayment by me or by my insurance carrier, I direct the health center to apply the overpayment to any other unpaid account I may have with JCH&L. I understand that in assigning benefits, JCH&L will submit my claim to my insurance carrier. This assignment specifically includes, but is not limited to, all benefits for all medical and hospitalization insurance; accident insurance; disability or loss-of-time insurance; Medicare, Medicaid, and CHAMPUS; benefits payable by alternative delivery systems such as HMOs and PPOs or arising from worker's compensation or occupation disease claims; and proceeds to which I am, or my estate is, entitled because of any judgment, settlement, or other claim or cause of action for damages if I was or am injured. This assignment may not be revoked as to services provided during this hospitalization or course of diagnosis and treatment. I also understand I am responsible for any amount not covered or paid by my insurance benefits.

11. **MEDICARE PATIENTS ONLY – ASSIGNMENT AND CERTIFICATION**

    I request payment of authorized Medicare benefits on my behalf for any services furnished to me by or in JCH&L. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. I certify that the information I have provided to JCH&L is true, accurate, and complete.

12. **MEDIGAP PATIENTS ONLY – ASSIGNMENT OF MEDIGAP BENEFITS**

    I request that payment of authorized Medigap benefits be made on my behalf to JCH&L for any services furnished by it to me. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services. Until revoked, this authorization applies to all occasions of service. This assignment is specific to the supplemental insurance information provided during registration (see scanned copy of the insurance card for policy number).

13. **COMMUNICATIONS**

    I agree that JCH&L, including its agents and independent contractors, may contact me by email, mail, or telephone through or by any contact information provided by me in the past or future or otherwise associated with my record, including cell phone numbers which could result in charges. The purposes of such contact may include appointment scheduling, education, telemarketing, debt collection, satisfaction surveys, or other purposes. I consent to JCH&L using technology, including prerecorded/artificial voice messages and/or automatic dialing devices, to contact me through the above-described means. If I discontinue use of any cell phone number I have provided, I will promptly notify JCH&L of the change. I hereby indemnify JCH&L and its agents and independent contractors from any expenses or other loss arising from my failure to notify JCH&L of the change.

14. **PATIENT RIGHTS AND RESPONSIBILITIES**

    I understand that I have certain rights and responsibilities as a patient. I have been given or offered information on patient rights and responsibilities.

15. **IMAGE AND AUDIO RECORDING CONSENT**

I agree that medical images, photographs, audio recordings and digital or video recordings may be made while I am receiving care at JCH&L. I understand that the images and audio from such photography and recording may be used for my treatment and these images and recordings will become part of my medical information subject to uses and disclosures as described in the Notice of Privacy Practices.

16. **INFORMATION EXCHANGE**
JCH&L participates in CyncHealth (a state-wide information exchange formerly known as NeHII) and CommonWell (a nationwide information exchange), which were developed to share information so that participating health care providers can quickly view my health information when caring for me. By signing below, I acknowledge that I have been offered education about CyncHealth and CommonWell, and I understand that patient information will be included in CyncHealth and CommonWell unless I choose to opt out.

17. **PATIENT DIRECTORY**
I understand that unless I object, my name and location within the Hospital will be included in the patient directory, and this information will be given to those who ask for me by name. If I object to inclusion in the patient directory, visitors who ask for me by name will be informed there is nobody by that name in the patient directory, and calls, flowers, and mail will not be delivered to me. I understand that I may notify Hospital personnel of my objection to inclusion in the directory at any time during my hospitalization.

18. **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**
With my signature below, I acknowledge that I have been given an opportunity to review JCH&L's Notice of Privacy Practices.

19. **NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES (§ 92.11)**

ATTENTION: If necessary, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-402-729-6856 (TTY: 1-800-833-7352) or speak to your provider.

20. **NOTIFICATION OF NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS**
With my signature below, I acknowledge that I have been given an opportunity to review JCH&L's nondiscrimination and accessibility Practices described below and I may ask for a copy of this document.
Discrimination is Against the Law
Jefferson Community Health & Life, JCH&L – Gardenside, JCH&L – Fairbury Clinic, & JCHL – Home Health (JCH&L) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)
JCH&L does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.
JCH&L:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, other formats).
Provides free language assistance services to people whose primary language is not English, which may include:
Qualified interpreters
Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Health Center's CFO and Section 1557 coordinator at 402-729-6856.

If you believe that JCH&L has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Chance Klasek, CFO and Civil Rights Coordinator, 2200 H Street, Fairbury, NE 68352, 402-729-6856, TTY: 1-800-833-7352, fax 402-729-2102, chance.klasek@jchealthandlife.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Chance Klasek, CFO and Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The undersigned certifies that he/she is the patient, patient's representative, or is the duly authorized by the patient to sign this document; that he/she has read and understands the contents of this consent for treatment form; and that he/she accepts these conditions. The information that has been provided is true and complete. A photocopy of the record of consent for treatment shall be valid as the original. I understand that I may ask for a copy of this consent and any other documents described above.

Patient Name: ____ Date of Birth: ______________________

Patient/Responsible Party(s) Signature(s): ____ Date: ____________

Name of Responsible Party (if applicable): ____

Facility Representative/Witness Signature(s): _____________________________________ Date: _____________

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