PERMISSION TO TREAT

GENERAL PERMISSION TO TREAT:

Emergency Department Patients: Patients presenting to the Emergency Department have the right to receive an appropriate medical screening exam performed by a doctor, or other qualified professional, to determine whether they are suffering from an emergency medical condition or are in active labor, and if so, to receive stabilizing treatment (including delivery of a baby including the placenta) within the capabilities of the GHS staff and facilities. Patients have these rights even if they cannot pay for services, do not have health insurance, or are not entitled to Medicare or Medicaid.

I am the Patient named above (or the person authorized by law to make decisions for the Patient). I give permission to Greenville Health System ("GHS") and the physicians, health care providers, staff and outside companies providing services at GHS, to order and provide routine hospital and health care services, including diagnostic, laboratory, and treatment procedures, that in the judgment of the provider(s) are necessary to diagnose and treat my symptoms or conditions.

Diagnostic and laboratory procedures that may be ordered for me (and/or my newborn infant) include (but are not limited to) testing for diseases such as Human Immunodeficiency Virus (HIV), Hepatitis, any other diseases categorized as contagious or sexually transmitted diseases, and Methicillin-resistant Staphylococcus aureus (MRSA). I understand that I can discuss these tests with my health care provider and can tell my health care providers (nurses, technicians and physicians) if I do not want to be tested for any one or all of these diseases. If I do not refuse these tests, I may be tested and those results will be included in my medical record. If the test results are positive, the results will be shared with me. If a health care worker comes in direct contact with my blood or body fluids, I understand that South Carolina law allows my blood to be tested without my consent for the Hepatitis B virus, Hepatitis C virus, or HIV to determine whether or not the viruses are present. The results of the test(s) will be made available to me and to the health care worker who was exposed.

Unless otherwise discussed with me, I authorize GHS to dispose of specimens, tissues, medical devices, or implants removed from my body during my treatment.

HEALTHCARE PROVIDERS: I understand that doctors who are providing services at GHS are members of the GHS medical staff, but they may not be employees or agents of GHS. Many providers, including doctors, physician assistants, nurse practitioners and certified nurse midwives, are non-employed, independent providers. I understand that GHS is not responsible for any act or omission by a provider who is not an employee or agent of GHS. I also understand that GHS is a medical teaching institution and that students and residents may be involved in my care with appropriate required supervision.

TELEMEDICINE: Health care services may be provided via telemedicine which means an image, video recording and/or audio of me may be used to allow health care providers at different locations to see me on a computer screen or view my medical records. Telemedicine may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: my medical records, medical images, live two-way audio and video, output data from medical devices and sound and video files. Electronic systems used will incorporate network and software security protocols to help protect the confidentiality and integrity of patient identification and imaging data.

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ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS:
If I have insurance, I agree to assign to GHS any and all rights including money from the following: TRICARE major medical benefits, PIP (personal injury protection), sick benefits, workers' compensation benefits, physician benefits (excluding any benefits payable to physicians who are not employees or agents of GHS), injury benefits, or any other health, accident or welfare benefits of any type or form, whether insured or self-funded, proceeds of any liability settlement or judgment being paid by or on behalf of a third party, or any other benefits due from the insurance policy. I also assign to doctors who are not employed by GHS, any proceeds of the foregoing benefits being paid by or on behalf of a third party or due from any insurance policy for services provided at GHS (such as pathologists and other private doctors). I warrant and represent that any insurance or any plan which I assign is valid insurance and in effect and that I have the right to make this assignment. All amounts collected will be applied to my account. In the event a claim for payment submitted by GHS to my insurance carrier or plan administrator is denied, I authorize GHS to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of Patients; plan or policy, appeal or file a legal/equitable action. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901, et seq., this review process will include, but is not limited to, a review by the Office of Personnel Management. In the event I am a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C §1001 et seq., I designate GHS as my authorized representative and grant to GHS the authority to act on my behalf in pursuing and appealing a benefit determination under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary of the plan description.

MEDICARE PATIENTS: If I am eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to GHS on my behalf. I certify that the information given by me is correct, in applying for payment under Title XVIII of the Social Security Act.

FINANCIAL AGREEMENT: I understand that I am obligated to pay my account according to the regular rates and terms of GHS, except for those services, provided in accordance with a clinical research trial, which are specifically identified in writing as services for which I am not obligated to pay. I do hereby appoint GHS as my representative to collect the claims, endorse the checks, and give full and final receipt for all amounts collected. In the event benefits exceed the actual charges for this account, I authorize GHS to apply the over payment to any other account(s) for which I am responsible with any entity of GHS, including GHS Partners in Health, Inc., Greenville Health Corporation, and/or any other entity, whether now or later is a part of GHS. If there is no other outstanding accounts for which I am responsible, the payment will be posted to the intended account and a refund processed accordingly.

I understand that GHS may obtain my credit report for review in collection of this debt. In the event that this account is placed with a collection agency or an attorney for collection, I will be responsible for paying all costs of collection, including attorney's fees.

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CONTACTING PATIENTS: I give permission to be contacted by GHS and/or GHS Partners in Health, Inc. and its employees and outside contractors including debt collection companies through any contact information that I have provided to GHS and/or GHS Partners in Health, Inc. for any purposes related to my medical diagnosis, treatment, fundraising, community service, unsolicited advertisements, marketing, payment for services, debt collections for bills owed, or for any other purpose related to treatment, payment or business operations. (This permission to contact also applies to outside independent companies and doctors and their employees who provide services in or for GHS facilities.) I give my permission to GHS contacting me in ways that may cause me to be charged a fee, and I will be responsible to pay the fees related to cell phone, home phone, work phone, text message, email or fax usage for contacts made by GHS. I give permission to GHS using automated dialing and/or artificial or prerecorded voice messages when contacting me by cell, home or work phone, patient room phone, paging service, specialized mobile radio service, radio common carrier service, or by or through any other service for which the called party will be charged a fee for the call or a fee for the data used or a fee for the minutes used for any reason listed above. I give permission to be contacted by GHS using email for transmission of notices regarding billing statements and SMS text message for appointment reminders. Such notices are unencrypted and are, therefore, considered unsecure communications but they will not include any clinical information. I understand that this permission to contact will allow GHS to call me using phone numbers that I may have listed on National or State Do-Not-Call Registry(s).

DISCLOSURE/USE OF HEALTH INFORMATION: I understand that uses and disclosures of my personal and health information are described in the GHS Notice of Privacy Practices (NPP). These include providing information to other providers through various methods, including to the GHS Health Information Exchange (HIE), for continuing care, to an insurance company or other payor (such as Medicare) to process payment, and for GHS health care operations such as medical education, peer review and outcomes analysis activities. I acknowledge by signing below that I have had the opportunity to receive a copy of the NPP. I also consent to the following:

- **Mother/Baby Record.** If I am getting care that may affect a baby that I am carrying or have delivered, I consent to any information being put into the baby's medical record, including, but not limited to, psychiatric, drug/alcohol abuse, or any information about testing/treatment for HIV/AIDS, syphilis, communicable, venereal, or other infectious diseases, or my medical history.
- **Directory/Patient Door**. Unless I inform hospital personnel otherwise, I consent to my name being listed in the Hospital Directory, along with my location, general condition and religious preference to allow clergy visits.
- **Consent to Use and Disclose Sensitive Information.** I specifically consent to any and all of my personal or medical information being used and disclosed to my health care providers and through the HIE as noted in the NPP, including (but not limited to):
    - Information about genetic testing, such as lab tests of my DNA or chromosomes conducted to discover diseases or illnesses of which I am not showing symptoms at the time of the test and that arise solely as a result of defects or abnormalities in genetic material.
    - Information showing (1) whether I have been diagnosed as having AIDS; (2) whether I have been or are currently being treated for AIDS; (3) whether I have been infected with HIV; (4) whether I have submitted to an HIV test; (5) whether an HIV test has produced a positive or negative result; (6) whether I have sought and received counseling regarding AIDS; and (7) whether I have been determined to be a person at risk of being infected with AIDS.

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- Information about suspicion of, diagnosis for, or treatment of mental illness or developmental disability.
- Information about communicable, venereal, infectious and/or sexually transmitted diseases (ex. HIV/AIDs, Hepatitis, Syphilis, Tuberculosis, Chancroid, Gonorrhea, etc.).
- Information about pregnancy; prevention of pregnancy (including birth control); child-birth; abortions.
- Information about diagnosis, treatment, detoxification or rehabilitation for alcohol or drug use or abuse.

PATIENT RIGHTS: I understand that I have certain rights and responsibilities that are set forth in the Patient Rights and Responsibilities handout. I acknowledge by signing below that I have received a copy of the GHS Patient Rights and Responsibilities handout.

PHOTOGRAPHING AND VIDEOTAPING: I understand that GHS may take photographs, video or audio recordings of me only in the course of and for purposes of my treatment, and that GHS will only use any photographs, videos or audio recordings internally for diagnosing, treating or for healthcare operations.

PERSONAL VALUABLES/BELONGINGS: I agree not to bring dangerous items onto GHS property. GHS reserves the right to search my property and room for dangerous items. I understand that GHS is not responsible for personal property kept in my room including false teeth, glasses and other prosthetic devices. GHS is NOT responsible for personal property, including money, unless GHS has issued a receipt for safekeeping of the personal property. GHS is a NO SMOKING facility. To ensure safety, I will allow GHS to keep my smoking materials until discharge, or may send them home with family or friends. I understand that this policy is strictly enforced.

HEALTHCARE ASSOCIATED INFECTIONS: Healthcare associated infections can be a complication of hospitalization. The SC Hospital Infections Disclosure Act, S.C. § 44-7-2410, requires hospitals to monitor and report targeted healthcare associated infections to the SC Department of Health and Environmental Control (DHEC). These reports are available on the following website for public view: http://www.scdhec.gov/Health/FHPF/InfectionControlHIDA/HospitalInfectionControl/

I understand that the practice of medicine and the security of personal or health information is not an exact science and that not all risks can be eliminated and that NO GUARANTEES HAVE BEEN MADE TO ME.

I SIGN BELOW ACKNOWLEDGING THAT I HAVE READ, ASKED QUESTIONS AND UNDERSTAND AND AGREE TO ALL 4 PAGES OF THIS FORM.

DATE/TIME	SIGNATURE OF WITNESS	SIGNATURE OF PATIENT/LEGALLY AUTHORIZED REPRESENTATIVE
DATE/TIME	SIGNATURE OF SECOND WITNESS (NECESSARY ONLY FOR TELEPHONE CONSENT)	PRINT NAME AND RELATIONSHIP IF OTHER THAN PATIENT

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