GENERAL CONSENT

1. I, the undersigned, acting on my behalf or as the legally authorized representative of ____________________________ ("Patient") hereby consent to the examination and treatment of my illness or medical condition by the medical staff, nursing staff and other health care providers (collectively, "Providers") of Broward Health ("BH"), and to the performance of any service, diagnostic test and/or procedure deemed necessary by my physician or BH Providers. I understand that I have the right to more complete information regarding any particular diagnostic or therapeutic procedure and that I may be asked for a more specific consent for certain procedures.

2. I understand that the practice of medicine and surgery is not an exact science and that the diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me regarding the results of any examination, care or treatment in a BH facility.

3. I understand that BH is a teaching facility and that medical, nursing and other healthcare personnel in training may participate in my care unless I request otherwise. These individuals are not necessarily employees or agents of BH.

4. I agree that BH may photograph or videotape me and/or aspects of my care and treatment as may be medically necessary.

5. I acknowledge that BH may retain, preserve, dispose or use for scientific, research, therapeutic, or teaching purposes, any specimens or tissues taken, unless I request otherwise.

6. I understand that there may be circumstances under which information about my care must be disclosed or reported. Such circumstances may include requirement for disclosure of information regarding cases of HIV, tuberculosis, viral meningitis, and other diseases that are reported to organizations such as health departments or the Centers for Disease Control and Prevention.

7. I further consent to the hospital conducting blood-borne infectious disease testing, including but not limited to testing for Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV), where a physician orders such tests when ordered by protocol for significant occupational exposures. The results of this test will become part of my confidential medical record, unless otherwise provided by law.

8. I understand that BH will not be responsible for any Patient's valuables, money or personal belongings retained by the Patient unless placed in BH's safe.

9. **RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**:
   I hereby authorize the release of my medical information, including protected health information, concerning my examination, testing, treatment and diagnosis to any third-party payor, including but not limited to Medicare, Medicaid, TRICARE and CHAMPVA for payment purposes. I understand that physicians and other Providers providing services to me may bill me directly and separately for medically necessary services or care, and that I am financially responsible for and guarantee payment of those charges. I authorize BH to release my medical records and information needed to determine and process any insurance, health care benefits, insurance or other third-party payor benefits to any physicians or other Providers who have provided medical services to me.

   Further, I authorize payment of any insurance or other benefits that may be made on my behalf by any party, including any third-party payor, PIP, Medicare, Medicaid and any other federal or state health care programs, directly to BH and/or any physician or other Provider. I understand that this assignment of benefits does not relieve me of my obligations to pay BH and/or physicians or other Providers for any charges not covered by this assignment or not paid by insurance or health care benefits.

   I request that payment of authorized Medigap benefits be made on my behalf to the Provider or Provider's assignee for any medical services furnished to me by that Provider; I authorize any holder of medical records or other information about me to release to the Provider, the Medigap insurance carrier and/or their designated agents any information needed to determine these benefit or benefits for related services.

   I understand and acknowledge, whether I sign as Agent or Patient, that I am responsible for and guarantee payment of any charges incurred for the care and services provided to Patient by BH. I further understand and acknowledge that BH will bill me for, and I will be responsible for payment of, any co-payment and/or balance after third-party payor's responsibility has ended, or any charge is that is not covered or paid by insurance, health care benefits or third party payors. I hereby designate BH as my representative for any ERISA claims. I authorize BH and its assignees to order a consumer credit report and verify other credit information. Should the account be referred to an attorney for collection, I agree to pay the costs of collection, including reasonable attorney's fees equal to 32% of the outstanding balance.

   I authorize BH to release my medical information, including mental health and substance abuse treatment records, to other parties (which may include providers, payors, business associates or other entities) for treatment, payment or healthcare operations.

10. I understand that BH contracts with physicians and physician groups to provide services to patients, and that they are independent contractors and are not necessarily the agents or employees of BH. I understand and agree that BH is not legally responsible for the acts and omissions of its independent contractors.

11. I hereby acknowledge that I have received (either now or in the past) BH's Notice of Privacy Practices for Protection of Medical Information for my review prior to receiving initial services through BH, its hospitals, clinics, physicians and other Providers.

12. I have read this document and have had an opportunity to have questions answered to my satisfaction.

SIGNED: ____ DATE: ____________________ TIME: ____________AM/PM
(Patient or person legally authorized to consent for patient)

Relationship to Patient: ______________________________________ Witness: ________________________________

Patient is unable to consent because ____

Consent is therefore given by the individual indicated below

____ DATE: ____________________ TIME: ____________AM/PM
(Patient or person legally authorized to consent for patient)

Witness: ________________________________

ADDRESSOGRAPH

CONSENT GENERAL

235

GENERAL CONSENT

WHITE - MEDICAL RECORD YELLOW - PATIENT ACCESS