Name:_____

DOB: _____ MR#:_____ CSN#:_____

Physician and Hospital Services Agreement

1. **Annual Agreement for Services:** I agree to the services that may be performed by a Mercy physician or non-physician provider ("provider") or facility. I understand I can withdraw this agreement at any time. This agreement applies to any provider services I may obtain from Mercy providers at a clinic or physician's office and also to any hospital services I may obtain at a Mercy hospital or from a hospital-based clinic location. I understand that except in an emergency, no major procedure or treatment will be performed without providing me an opportunity to give informed consent, meaning the provider will first provide me with information including the nature of the procedure or treatment, risks, benefits, and alternatives.

2. **Telehealth Services:** I give my permission for consult-based services that may be provided to me from another location by live video technology ("telehealth"). I understand that I can withdraw this permission at any time by telling my provider when telehealth services are recommended to me and that if I choose to withdraw this permission, there may be certain services that I am not able to receive at a Mercy facility. I also understand and agree that: (i) I may refuse telehealth services at any time without affecting my right to future care or treatment and without risking any third party payor benefits to which I am entitled; (ii) I will be informed of the alternatives, if any, to the telehealth services that are available to me; (iii) I will have the right to access the medical record of the telehealth services as provided by law; (iv) I give my permission for the sharing, storage, and retention of identifiable images or other information from the telehealth service, with the understanding that like in-person care, any identifiable images or other information will not be shared except as required or permitted by law; (v) I have the right to know who will be present during the telehealth services and may exclude anyone from either location; and (vi) there will be no videotaping or recording of telehealth services.

3. **Financial Agreement:** I guarantee and agree to pay for all goods and services provided to me or the patient named below at the rates listed in Mercy's Charge Description Master as of the date of treatment, or a different amount as may be determined under my (or the patient's) insurance plan(s) or my (or the patient's) status as a Medicare or Medicaid beneficiary. Should an account be referred to an attorney or collection agency for collection, I will pay attorney's fees and collection expenses. Mercy will provide a medical screening exam to anyone in need of emergency medical treatment, regardless of ability to pay.

4. **Assignment of Insurance Benefits:** I assign to Mercy, my physician or other non-Mercy healthcare professionals involved in my (or the patient's) care my (or the patient's) rights under all insurance and benefit plan documents, and authorize direct payment to each healthcare provider of all insurance and plan benefits payments for services provided to me (or the patient) by these providers. By paying my providers directly, my insurance company or employer is fulfilling its obligations to me (or the patient) under the insurance policy, or

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the employer is fulfilling its obligations as required by law. I also agree that I (or the patient) am financially responsible for charges not paid according to this assignment.

5. **Medicare Assignment:** I certify that the information given by me in applying for payment from any third party payor, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my (or the patient's) behalf, and I authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my (or the patient's) eligibility for coverage under Medicare Part A and Part B, including but not limited to the effective date of such coverage. I also authorize Mercy to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.

6. **Notice of Privacy Practices:** I acknowledge that I have received a copy of the Notice of Privacy Practices (NOPP), which describes when Mercy may use or disclose information for treatment, payment and health care operations. The NOPP is considered part of this Agreement by this reference. I understand that the NOPP is only provided the first time I receive services from the hospital and is otherwise available upon request and on Mercy's website.

7. **Images and Monitoring:** I understand that Mercy may make and use recordings, films, or other images for identification, diagnosis, treatment, performance improvement, or educational purposes. I understand that Mercy may provide or make available monitoring services through mobile application, medical device, or other technology. I understand that Mercy facilities may use video monitoring in patient care areas when there is clinical need and in common areas for security purposes. I consent to such images, technology and video monitoring, with the understanding that any images, audio, or data are not readily available to visitors or the public and will not be disclosed except as required or permitted by law.

8. **Legal Relationship between Hospital and Provider:** I understand that when I am hospitalized, I am under the care and supervision of my attending provider, and it is the responsibility of the hospital and nursing staff to carry out his/her instructions. It is the responsibility of my provider or surgeon to obtain my informed consent, when required, for specific medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under instruction of the provider.

9. **Clinic and Hospital Rules:** I understand that my visitors and I must obey all Mercy clinic and hospital rules. I understand that if I or my visitors do not follow the rules, Mercy may pursue corrective action.

10. **Personal Valuables:** I understand that as a patient, I am encouraged to leave valuable personal items at home. While Mercy may maintain a safe for small personal items of usual value, Mercy is not responsible for the loss or damage to these items.

Mercy

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11. **Demographic Information:** I have reviewed the demographic information listed for me and confirm that it is correct. I am aware that I need to inform Mercy of any changes as soon as possible.

12. **Independent Contractor/Provider:** I understand that separate bills may be sent for professional services from non-Mercy providers such as radiologists, pathologists, and anesthesiologists, in addition to the Mercy bill.

13. **Phone Calls, Text Messages:** I authorize Mercy and its collection agencies to contact me, or a representative I appoint, about my account or my experience, including using any contact information or cell phone numbers that I have provided or will provide, or that is available to Mercy from third parties. I authorize contact with me by telephone, voice message, and text message and authorize the use of automated dialing and texting technology and artificial or pre-recorded voice, even if I am charged for the call or text under my phone plan. I agree such contact will not be "unsolicited" for purposes of local, state or federal law. I agree that Mercy and its collection agencies may monitor and/or record any communication. If I wish to opt out of this Section 13, I understand that I may contact the registration department of the Mercy facility where I received services.

A copy of this form shall have the same force and effect as the original. The undersigned is the patient or is duly authorized to act on behalf of the patient to sign for the patient and accept the terms written above. A signed copy of this form is available upon request.

Signature: _____ Date: _____Time: _____

If signed by other than patient, indicate relationship: _____