MARGARET MARY HEALTH

P.O. Box 226 • 321 Mitchell Avenue
Batesville, IN 47006
Phone: 812.934.6624

Patient Label

PATIENT CONSENT AND CONDITIONS OF TREATMENT

Thank you for seeking care from Margaret Mary Health ("MMH"). This Patient Consent, once executed by you or your authorized representative, evidences your authorization to permit MMH and its Health Care Practitioners to provide you with medical care, share your health information, receive payment for the services rendered, and documents your agreement to other particular office practices and conditions of treatment that are set forth below. You or your authorized representative must sign this form prior to treatment and must update this form as may be requested by Margaret Mary Health.

I. GENERAL CONSENTS AND ACKNOWLEDGMENTS

I request, authorize, and consent to MMH and all MMH employed or contracted physicians and other licensed or certified health care practitioners, their associates and assistants, (collectively referred to herein as "Practitioners"), participating in the care of me/my child to provide and perform such medical and surgical care, mental health services, tests, procedures, and other services and supplies as are considered advisable by my Practitioner(s) for my health and well-being. Whether performed at MMH, at another facility/location, or by way of telemedicine, my consent shall include, but not be limited to, the use of drugs, medicines, laboratory procedures, X-ray and imaging procedures, and diagnostic testing, immunizations, preventative medicine procedures, routine recreational activities, and the use of local anesthesia during laboratory procedures and diagnostic testing.

I further authorize and consent to allowing medical residents and students, as part of their training in health care education and while under appropriate supervision, to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at MMH. When my care is provided in a school setting, I also authorize and consent to allowing school nurses and other appropriate health professionals to participate in or observe the delivery of my medical care and treatment.

II. CONSENT FOR BODY FLUID-BORNE INFECTIOUS DISEASE TESTING

I authorize and consent to MMH and my Practitioners 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 a Practitioner orders such tests or 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 collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding, or soreness at the puncture site. These test results will become part of my medical record.

CONSENPT

Patient Label

III. PHOTOGRAPHY/VIDEO/RECORDINGS

I authorize and consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for purposes of documenting care and treatment and other treatment-related purposes, as well as security purposes and/or the Hospital's quality improvement and/or risk management activities. I understand that MMH retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of MMH without a specific written authorization from me or my legal representative unless otherwise required by law. Notwithstanding the foregoing rights of MMH, I understand and agree that neither I, nor any individual visiting or accompanying me, are permitted to take pictures or make video or audio recordings of my care, other patients, MMH agents or employees, Practitioners, or students at MMH.

IV. SEARCH OF ITEMS BROUGHT ONTO HOSPITAL PREMISES AND PERSONAL VALUABLES

In order to maintain the safety of its premises, I acknowledge and agree that MMH reserves the right to search all items brought onto its premises including purses, wallets and other personal effects. If MMH determines, within its sole discretion, that an item poses a potential safety threat, MMH will: (1) dispose of the item; (2) place the item in a secure location (if available) within MMH until the time of discharge; or (3) turn over the item to law enforcement. If you do not wish for your belongings to be searched and possibly removed from your possession, please refrain from bringing such items onto MMH premises.

I understand and agree that MMH will not be liable for any personal articles that are lost, stolen or damaged. MMH encourages patients to leave personal items and valuables at home. If this is impossible, MMH will place valuables in a secure location at MMH (if available) upon request.

V. SUBMISSION OF CLAIMS/ASSIGNMENT OF PAYMENT/ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I authorize MMH and Practitioners, as applicable, to submit claims to Medicare, Medicaid, insurance earners, employee health benefit plans and/or other third-party payers (collectively referred to as "Plans") for services provided to me at MMH. I hereby assign any payment otherwise payable to me from Plans to MMH and Practitioners who provide services, care or treatment to me at or on behalf of MMH. I acknowledge that I am responsible for knowing the limitations of my Plan benefits and agree to be personally responsible for paying the charges billed for services, care or treatment that my Plan deems to be: (i) not a covered benefit; or (ii) in excess of the Plan's benefit limitation.

I acknowledge that a Practitioner who does not contract with my Plan or participate in my Plan's network (an "Out of Network Provider") may be called upon to render items or services during the course of my treatment, or I may receive a referral to obtain items and services from an Out of Network Provider.

Patient Label

V. SUBMISSION OF CLAIMS/ASSIGNMENT OF PAYMENT/ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY
I understand that my Plan may apply different coverage and payment limitations to items and services rendered by Out of Network Providers, and that I may contact my Plan for assistance, including identification of Practitioners currently in my Plan's network, prior to obtaining such items and services.

MMH will make a reasonable effort to verify my Plan's coverage for the services, care and treatment I am expected to receive at MMH and to notify me, in advance, of items it knows are not covered benefits. However, should my Plan ultimately deny payment for the services, care and treatment provided to me by MMH and/or its Practitioners, I am responsible for paying the billed charges for such items, consistent with any applicable written contractual discounts and MMH's patient financial assistance policies.

I agree to promptly pay, when requested by MMH or my Practitioner(s), the difference between MMH's and/or Practitioner's billed charges for the services, care and treatment I received and the amount covered by my Plan benefits, other than those amounts excluded by a written contractual agreement and/or MMH's patient financial assistance policies. Upon request, an authorized patient representative will be made available to explain eligibility for financial assistance under such policies. I agree that account balances after insurance must be paid in full within thirty (30) days of patient billing, unless other payment arrangements have been made, to avoid collection placement.

If MMH or any Practitioner refers my account for collection, I acknowledge and agree that I will be responsible for paying the cost of collection, including reasonable attorney fees, expenses and interest as allowed by Indiana law. I also acknowledge and agree that I may be charged a fee for any checks returned by the bank. I authorize MMH and all Practitioners who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone, which could result in charges to me, and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication to discuss any past, future or current services, including the collection of any past due amounts.

I additionally acknowledge and agree to the following:

- I am expected to bring my current health insurance card to the office at the time of each visit and to notify MMH at time of check-in of any changes to insurance information or contact information.
- I am expected to pay my co-payment and/or deductible at the time of service; or if I do not have insurance, I am expected to pay for my visit in full, or otherwise establish a payment plan approved by MMH, at the time of my visit.
- If I have any questions regarding my bill, I may contact the MMH billing office at 812-932-3371.

VI. RELEASE OF INFORMATION
I hereby acknowledge and agree that MMH and Practitioners may release my healthcare information for purposes of treatment, payment or healthcare operations.

Patient Label

VI. RELEASE OF INFORMATION

Healthcare information regarding a prior admission(s) or services received at other Margaret Mary Health affiliated facilities about me may be made available to subsequent Margaret Mary Health facilities to coordinate patient care or for case management purposes.

Healthcare information may be released 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. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation or when otherwise authorized by me.

If I am covered by Medicare or Medicaid, I authorize the release of my 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. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

Federal and state laws may permit MMH to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of patient's health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that MMH may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

In the event I request a copy of or transfer of my patient records, I understand that I will be required to make this request in writing. I further acknowledge and agree that I will be assessed a charge for this service depending on the nature of the request made. All such balances must be paid before records are transferred.

VII. NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that MMH's Notice of Privacy Practices provides information about how MMH and my Practitioners may use and disclose protected health information about me. By signing this form, I acknowledge and agree that I have either: (a) received and reviewed a copy of the Notice of Privacy Practices; or (b) have been offered an opportunity to receive and review the MMH's Notice of Privacy Practices but do not wish to do so. I understand that the MMH reserves the right to change its Notice of Privacy Practices and that I may request a copy of the revision by contacting the Privacy Officer.

Patient Label

VIII. "NO SHOW" POLICY AND PATIENT CONDUCT

I acknowledge and agree that MMH requires patients to provide at least twenty-four (24) hours of notice if the patient will be unable to keep an appointment. I understand that missed appointments, a failure to timely present for a scheduled appointment, and any appointments that are cancelled less than twenty-four (24) hours prior to the scheduled appointment will be consider a "no show" and recorded in this manner.

I acknowledge and agree that after three (3) "no shows," MMH reserves the right to dismiss me from the MMH practice and affiliated practices. If I am a new patient to the practice, I acknowledge and agree that after two (2) consecutive "no shows," MMH will not schedule me further.

Further, I acknowledge and agree that I will at all times comply with MMH's policy and expectations for appropriate conduct, as well as my obligations for payment (as set forth above). In the event MMH determines that I have violated such policy, expectations, or obligations, I acknowledge and agree that MMH reserves the right to dismiss me from the MMH practice and affiliated practices.

ACKNOWLEDGMENT AND SIGNATURE:

By my signature below, I represent that I am the patient or that I am the patient's legal representative and the guarantor of the patient's account pursuant to the financial acknowledgment described above. I represent that I have fully read and understand each page of this five (5) page Patient Consent and Conditions of Treatment document, and I agree to be bound by its terms. I acknowledge that all of my questions regarding this consent document have been answered to my full and complete satisfaction. I understand that I have the right to revoke this consent at any time, except to the extent MMH or Practitioners have acted in reliance on it.

Patient/Legal Representative Name: _____ Relationship to Patient: _____

Signature of Patient/Legal Representative: _____ Date: _____

Witness to Signature of Patient: _____

Witness Signature: _____ Date: _____