RIDGEVIEW GENERAL CONSENT & AUTHORIZATION FORM

For opt-out options, please ask registration. We cannot accept any other changes to this form.

CONSENT FOR TREATMENT:
I consent to and authorize Ridgeview providers and other healthcare workers to perform appropriate health care examinations, treatment, diagnostic testing, lab tests and operations and to give medicines that they believe is necessary or helpful to my health. I know there are risks with all medical treatment and procedures and I understand no one can guarantee how well treatments or procedures will work.

I consent for medical photographs and/or videos to be made of me (or the person for whom I am legal guardian). I understand that they may be used as part of my care or treatment, in my medical record and/or for purposes of medical teaching.

CONSENT TO RELEASE INFORMATION: ***Your privacy is important.***
Ridgeview will use your protected health information for the following:

For Treatment: I understand Ridgeview and its agents will:
- share my medical information with other healthcare professionals, facilities, and anyone else Ridgeview believes to be involved in my care, treatment, case management, discharge planning and related services.
- share my information with a health information exchange, record locator service or patient information service. My information may be shared with and accessed by other health care providers and entities for treatment, payment, and the health care operations of those organizations.
- access and/or seek health information about me and the location of my health records through a record locater service or patient information service.
- access my current prescription history of controlled substances in any state database, such as the Minnesota Prescription Monitoring Program (PMP), when consent is required under state law.

For Payment: I understand Ridgeview and agents of Ridgeview will:
- share my medical information and account records with my health plans and payers, their agents and others as needed for payment purposes (such as eligibility and coverage determinations, billing, processing claims, coordinating benefits and utilization review) and as otherwise required by my health plan and other payers.
- share my medical information with suppliers of medical equipment, special transportation, or other health services so they can request payment from my insurance or other payer.
- share my medical information with my employer or potential employer for only those services provided at Ridgeview to conduct an evaluation relating to medical surveillance of the workplace; or work-related illness or injury.

For Health Care Operations: I understand Ridgeview and approved agents (including Business Associates) of Ridgeview will:
- share my medical information with others (where consent is required) to improve the quality of my care and experience, and to manage its business operations. This includes sharing my information with accrediting and quality organizations, regulatory agencies, and public health agencies that are responsible for licensing and accreditation, fraud investigation, care management, immunization tracking, public health reporting, drug and device defects or recalls, and quality evaluation.
- share my medical information with organ donor organizations to assist donations.
- disclose my presence as a hospital patient. This allows me to have visitors, phone calls and mail. If I do not want others to know I am in the hospital, I will tell a staff member when I register.
- disclose my presence and religious preference to Community Faith Leaders or Clergy of my denomination.
- reveal my presence to foundations that support Ridgeview and its mission.

Health Plan Information: I permit my health insurance plan to release to Ridgeview my protected health information about services I have received from Ridgeview and other care providers. Ridgeview may use this to treat me, manage and coordinate my care, and for case management, payment, accreditation, and quality review.

Family Guarantor Billing: If I have agreed to take part in Family Guarantor Billing, I agree that my bill can be combined into one statement that covers my current spouse and minor children with the same mailing address. The statement will be sent to the guarantor listed on the account. The combined bill will include patient name, the date of service, the location of service, a summary of the services received (including type or name of diagnostic tests) and the amount due. I permit Ridgeview to discuss issues of billing or payment with an adult family member listed on my guarantor account. That person must give my name, address, date of birth, and my Ridgeview account number(s) as well as his or her own name and address.

Telehealth: I consent to treatment via telehealth. I understand that Ridgeview may use third party, web-based video conferencing vendors to aid real-time treatment sessions with my health care provider and electronically transmit my health information. In rare cases, the information transmitted may be of poor quality. If the equipment is not working, there could be delays in evaluation and treatment. Telehealth appointments are not appropriate when seeking emergency treatment, call 911.

PATIENT LABEL

AUTHORIZATION TO ASSIGN BENEFITS

Insurance, assignments of benefits and guarantee of account:

- I agree that payments approved by payers may be paid directly to Ridgeview on my behalf for any services and/or treatment I received from a Ridgeview provider and/or in a Ridgeview facility. I permit any holder of medical or other information about me to release to payers and their agents any information needed to determine these benefits or benefits for related services. I understand that I must meet the requirements of my insurance policies.
- I agree to pay any charges not covered by insurance, government programs (including Medical Assistance and Medicare), or other funds. I agree to pay reasonable attorney fees and all costs of collection if my account is turned over to an attorney or collection agency. I understand that it is my responsibility alone to negotiate payment of a claim that is disputed by the payer.
- For Medicare Patients only: I approve Ridgeview to use my 60 lifetime reserve days as needed after my regular Medicare Benefits expire. I understand if reserve benefits are used, there will be co-insurance due. Once used, they are permanently reduced by the number of days used.

SERVICE TERMS & MISCELLANEOUS

A copy of the Patient Bill of Rights, information on Healthcare Directives, and information about how to file a complaint has been offered to me.

I agree that Ridgeview, its affiliates and agents, may use an automated telephone dialing system to make phone calls or send text messages to my home phone and cellphone number(s) that I gave to Ridgeview for treatment, appointment reminders, payment, health care operations and other notification purposes. I understand that message and data rates may apply, that I may opt out of future notifications at any time and that delivery of information and content to a mobile device may fail due to a variety of circumstances. Accordingly, neither Ridgeview or the carriers are liable for any delays or failures in the receipt of any text messages.

I agree that I am responsible for my personal valuables (such as money, jewelry, dentures, hearing aids, and eyeglasses) while a patient at Ridgeview. While a patient, I have been encouraged to send all personal items of value home with relatives or friends. I have been informed of the availability of safekeeping of my personal valuables. I release Ridgeview from any liability for loss or damage of my personal valuables by theft or negligence by me or any Ridgeview employee.

I understand video surveillance is used for patient safety and treatment purposes. Ridgeview respects patient privacy per video surveillance policies.

I understand that Ridgeview will not tolerate any type of threatened or actual violence committed by or against a patient, personnel, visitors, volunteers, or any piece of Ridgeview property. Where appropriate, Ridgeview will report violent incidents to local law enforcement authorities.

If this is my first visit to a Ridgeview location, a copy of the current Notice of Privacy Practices has been offered to me. It is available to me via postings in the registration areas and on the website www.ridgeviewmedical.org. I understand that I can ask for a copy of the Notice at any time.

- I understand that this consent ends one (1) year from the date signed except for purposes of payment and sharing with Health Information Exchanges that require expressed revocation.
- I understand that I may take back this permission at any time by notifying Ridgeview in writing. No further release will take place after the date notified.
- I understand that other parties may use or disclose health information received from Ridgeview.
- I understand that I can receive a copy of this form upon request.

Ridgeview Arlington and Ridgeview Le Sueur Campuses only: I acknowledge that I understand that a Doctor of Medicine or Doctor of Osteopathy may not be present during all hours services are furnished to me.

By signing, you agree that you understand and accept the terms on this form.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is unable to sign, a legally authorized person must sign and date the form. State your legal authority and provide legal documentation if not already on file:

  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

  ☐ Other Legal Representative _____

  Note: If none of these apply and this is a medical emergency, the signer has the following relationship with the patient:

  _____

- If the patient is 17 years or younger, the patient's parent or legal guardian must sign and date this form, unless an exception exists under state or federal law.

  State your relationship: ☐ Parent ☐ Legal Guardian (provide legal documentation if not already on file)

_____ _____ _____

Signature *Date/Time signed* *Printed Name of the Person Signing (if not Patient)*

_____ _____

Witness Signature *Date/Time signed*

_____

Printed Name of the Person Signing (if not Patient)

PATIENT LABEL