***For purposes of this Consent and Authorization, UF Health describes a collaboration of the University of Florida Board of Trustees for the benefit of the University of Florida College of Medicine, Shands Jacksonville Medical Center, Inc., Shands Teaching Hospital and Clinics, Inc., and Shands Recovery, LLC. Collectively, these entities are referred to as UF Health in this form.**

Consent and Authorization for Routine Treatment I consent to and authorize UF Health*, my physicians and health care providers (collectively my providers") to provide or order the routine medical care, diagnostic and laboratory procedures, which my providers believe to be necessary. I understand UF Health is affiliated with a teaching institution, and that residents, interns, students, and other individuals may observe or participate in my care, treatment, and services ("Care I consent to UF Health taking photographs and/or video/audio recordings of me in the course of and related to my Care, and to their use of such photographs or videos and my medical data for educational purposes within UF Health. I authorize UF Health to retain, preserve, use for educational purposes, or to otherwise dispose of, any specimens, tissues, medical devices, or implants removed from my body during my Care.
Telemedicine: I understand and agree that my providers may utilize telemedicine (the electronic communication of medical information) including, but not limited to, videoconferencing, electronic transmission of imaging, and remote monitoring of vital signs as part of my Care. Except in emergency circumstances, my providers will explain the risks and benefits of telemedicine prior to the telemedicine encounter. I understand that I have the right to seek Care elsewhere in lieu of a telemedicine encounter.

Valuables Release - I understand and acknowledge that UF Health has no responsibility for the loss of any valuables or personal belongings ("property") unless those items are deposited with UF Health Security, and I release UF Health from all liability for loss of any property which I do not deposit with UF Health Security. All items deposited with UF Health Security that remain unclaimed for ninety (90) days will be considered abandoned and may be disposed of by UF Health.

Safety and Security -In order to protect the health and safety of patients, visitors and staff, I understand UF Health does not permit contraband on its premises (including guns, knives, other weapons, illicit drugs, or alcohol). I consent to a search of my person and belongings to identify and remove contraband should UF Health reasonably suspect the presence or use of contraband on its premises. If my providers reasonably suspect the use of contraband substances, I consent to an alcohol and/or drug test as necessary to provide me appropriate patient Care. I understand and acknowledge that UF Health has zero tolerance for harassing, aggressive or violent behavior by its visitors, staff, and patients. I agree that neither I nor my visitors will photograph, film, or record any provider without that provider's express consent.

Disclosure of Patient Information I authorize UF Health and my providers to release my health information (including information relating to mental health/psychiatric care, alcohol and/or substance abuse, genetic testing, and HIV tests) and any other information for treatment purposes and/or to obtain payment for charges incurred by me or on my behalf to: my providers or any affiliated provider; my referring or treating providers; any third party engaged in the collection or dissemination of my medication information; the guarantor on my accounts; any third party payors (defined as including, but not limited to, Medicare, Medicaid, Tri-care or governmental programs; health, accident, automobile or other insurance; workers' compensation payors, agents or administrators; HMOs; self-insured employers; and any sponsors who may contribute payment for medical services) or their agents; regional or national health information networks; and other providers of medical services and products related to or connected with this admission or course of Care.

I authorize UF Health to disclose my patient information to: business associates, public health and oversight agencies, regulatory entities, other health care providers or organizations who have provided me with Care to facilitate health care operations of any of these parties; residents, interns, students, and others in furtherance of educational purposes; disaster relief agencies as necessary to assist in their endeavors; law enforcement to correctly identify me or to report a crime; affiliated charitable foundations in connection with fundraising programs; and UF Health to send health promoting or informational materials to me. If my admission or treatment is due to a motor vehicle accident, I authorize UF Health or my providers to obtain a copy of my "crash report" required by Florida Statutes, in order to facilitate third party payment.

Medicare Reauest for Payment/Assignment of Benefits- I request payment of authorized Medicare benefits due to me or on my behalf for any services furnished to me by UF Health and my providers. I hereby assign to UF Health and my providers payment from Medicare, Medicaid and all third party payors with whom I have coverage or from whom benefits are or may become payable to me, for the charges I receive for, related to, or connected with Care (past, present, or future) I receive from UF Health and my providers. I agree to be personally responsible for payment for all Care that is not covered by my third party payors, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments.

Guarantor Agreement - I agree to the following: 1) I am responsible for UF Health's and providers' charges for this Care and past and future Care if related to the same accident or illness; 2) the charges are due and payable at the time of discharge or discontinuation of Care; 3) 1 agree to pay the charges in effect at the time Care is provided; 4) unless otherwise precluded by contract or law, if UF Health or providers bill third party payors, they do so as a courtesy, and UF Health and providers may demand payment in full of any balance due at any time; 5) if I have not paid a final bill within one hundred and twenty days (120) days, I may be declared in default, and the overdue account may be referred to a collection agency. I consent to UF Health or any third party contacting me by telephone, including my cellular phone, for purposes of collecting any amounts owed by me.

Lien on Third Party Liability Proceeds - If my Care is due to an accident or injury, UF Health shall have a lien upon the proceeds of any cause of action, suit, or settlement I receive related to such accident or injury, in order to recover payment for all charges for Care I receive related to such accident or injury (past, present, or future), effective as of the date Care was first provided.

(continued)

University of Florida and Other Independent Providers - I acknowledge that I will receive Care from Independent Providers (including, but not limited to, radiologists, anesthesiologists, pathologists, emergency physicians, surgeons, obstetricians, and perfusionists) who are NOT employees or agents of EITHER the University of Florida Board of Trustees OR any of the following (collectively referred to as the "Shands Entities Shands Jacksonville Medical Center, Inc.; Shands Teaching Hospital and Clinics, Inc.; or Shands Recovery, LLC. I further acknowledge that I will receive care from health Care providers who are employees and/or agents of the University of Florida Board of Trustees ("UF Providers but are not the employees and/or agents of any of the Shands Entities. To the extent that the law imposes any duty upon any UF Health hospital to provide certain services, I HEREBY- consent to the delegation of that duty to UF Providers and/or Independent Providers participating in my Care; discharge UF Health from any duties the hospital may have with regard such services; and give up my right to hold a UF Health hospital liable for any injury suffered as a result of a negligent act or omission based on any UF Provider or Independent Provider.

Risk Management and Dispute Resolution I agree that my patient information (including, but not limited to, my medical records, billing information, and information I disclose to a health care provider in the course of my Care) may at any time be used by and disclosed to employees, officers, agents, and legal representatives of UF Health, for purposes of risk management, and formal and informal dispute resolution processes (including, but not limited to, litigation and mediation) involving one or both entities.

Agreement to Mediate - In accepting Care at a UF Health facility, I agree that before I file any lawsuit against UF Health or any of its facilities, employees or agents arising out of the Care provided to me by providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third person who has been certified to be a mediator tries to help settle claims. UF Health will pay the cost of the mediator. I further agree that any mediation must take place in the State of Florida and in the county where my Care was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

By signature below, I acknowledge that I have read, understand, and agree **to the foregoing as applicable to me and/or my minor child(ren), if provided Care by or on behalf of UF Health, or if born during this admission or Care by UF Health. A signed copy shall be as valid as the original.**

Patient/Guardian/Guarantor: _____ Date _____

Printed Name/Relationship to Patient: _____ ☐ Self ☐ Guardian ☐ Guarantor ☐ Insured

Witness: _____ Date _____

NOTICE OF LIMITED LIABILITY

PURSUANT TO SECTION 101 2.965, FLORIDA STATUTES

I, ON BEHALF OF MYSELF, MY CHILD, AND/OR MY WARD, HEREBY ACKNOWLEDGE THAT:

THE MEDICAL CARE AND TREATMENT I, MY CHILD AND/OR MY WARD RECEIVE AT SHANDS TEACHING HOSPITAL AND CLINICS, INC., SHANDS JACKSONVILLE MEDICAL CENTER, INC., OR SHANDS RECOVERY, LLC, WILL BE PROVIDED BY EMPLOYEES AND/OR AGENTS OF THE UNIVERSITY OF FLORIDA BOARD OF TRUSTEES (UFBOT);

THE UFBOT EMPLOYEES AND/OR AGENTS PROVIDING THIS MEDICAL CARE AND TREATMENT INCLUDE BUT ARE NOT LIMITED TO: PHYSICIANS; PHYSICIAN ASSISTANTS; HEALTHCARE RESIDENTS, FELLOWS, AND STUDENTS IN TRAINING; ADVANCED REGISTERED NURSE PRACTITIONERS; NURSES; PERFUSIONISTS; AND TECHNICIANS, WHO WILL AT ALL TIMES BE UNDER THE EXCLUSIVE SUPERVISION AND CONTROL OF THE UFBOT; AND

THE LIABILITY FOR THE NEGLIGENT ACTS AND OMISSION OF THESE UFBOT EMPLOYEES AND/OR AGENTS IS LIMITED BY LAW TO $200,000 PER CLAIM OR JUDGMENT BY ANY ONE PERSON AND TO $300,000 FOR ALL CLAIMS OR JUDGMENTS ARISING OUT OF THE SAME INCIDENT OR OCCURRENCE (SEE SECTION 768.28(5), FLORIDA STATUTES).

I FURTHER ACKNOWLEDGE, ON BEHALF OF MYSELF, MY CHILD AND/OR MY WARD, THAT THE UFBOT EMPLOYEES AND AGENTS PROVIDING MEDICAL CARE AND TREATMENT AT A SHANDS TEACHING HOSPITAL AND CLINICS, INC., SHANDS JACKSONVILLE MEDICAL CENTER, INC., OR SHANDS RECOVERY, LLC. (collectively "SHANDS") FACILITY ARE NEITHER EMPLOYEES NOR AGENTS OF SHANDS.

_____

Printed Patient Name

_____ _____

Patient/Parent/Guardian Date

UF UNIVERSITY of FLORIDA

UFHealth UNIVERSITY OF FLORIDA HEALTH

If printed electronically, all pages must be stapled

Patient Name:

Date:

Medical Record Number:

Patient Rights and Responsibilities

You have the right to:

- Be treated with courtesy and respect, with appreciation of individual dignity, and with protection of privacy.
- A prompt and reasonable response to questions and requests.
- Know who is providing medical services and who is responsible for your care.
- Know what patient support services are available (including help with a hearing impairment, or an interpreter in your language if you do not speak English, at no charge to you).
- Know what rules and regulations apply to your conduct.
- Be provided with written information about advance directives and available health care decision-making options in Florida.*
- Formulate advance directives and to have the medical staff and hospital personnel caring for you implement and comply with your advance directives.
- Receive a "Notice of Beneficiary Discharge Rights," "Notice of Non-Coverage Rights," and "Notice of the Beneficiary Right to Appeal Premature Discharge," if you are a Medicare patient.
- Participate in decisions involving your health care, including consideration of ethical issues. You have the right to participate in the development, including any revisions, and implementation of your inpatient treatment/care plan, your outpatient treatment care plan, your discharge plan, and your pain management plan.
- Make informed decisions regarding your care, including the right to receive information from the health care provider about diagnosis, planned course of treatment, including surgical interventions, alternatives, risks, and prognosis and outcomes of care that may impact your decisions regarding treatment.
- Accept or refuse treatment, except as otherwise provided by law.
- Have a family member or representative of your choice and your own physician notified promptly of your admission to the hospital upon request.
- Be given, upon request, full information and necessary counseling on the availability of financial resources for your care.
- Know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive, upon request prior to treatment, a reasonable estimate of charges for medical care. Such reasonable estimate shall not preclude the health care provider or the health care facility from exceeding the estimate or making additional charges based on changes in your condition or treatment needs.
- Receive a copy of a clear and understandable itemized bill upon request and to have the charges explained.
- Impartial access to medical treatment or accommodations regardless of race, national origin, religion, sexual orientation, physical handicap, source of payment, age, color, marital status, or gender.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for experimental research purposes and to consent or refuse to participate in such experimental research knowing that refusal will not compromise access to any other services.
- Know the health care facility's procedure for expressing a grievance. You have the right to express grievances regarding any violation of your rights, through the grievance procedure of the health care provider or health care facility, which served you, and to the appropriate state agency.**
- Personal privacy, except as limited for the delivery of appropriate care.
- Receive care in a safe setting.
- Be free from all forms of abuse, neglect, and harassment whether from staff, other patients, or visitors.
- The confidentiality of your clinical records, except as provided by law.
- Except under limited circumstances, access information contained in your clinical records within a reasonable time frame.
- Access individuals outside the hospital by means of visitors and by written or verbal communication. When it becomes necessary to restrict communication, the therapeutic effectiveness of the restriction will be periodically evaluated.
- Retain and use personal clothing or possessions if space permits and it does not interfere with another patient or medical care.
- Be free from restraints or seclusion used as means of coercion, discipline, convenience, or retaliation.
- Appropriate assessment and management of pain.
- Access any mode of treatment, including complementary or alternative healthcare treatments, that is, in your own judgment and the judgment of your physician(s), in your best interest, to the extent that such mode of treatment is offered by the hospital.

It is your responsibility to:

- Provide to the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- Report unexpected changes in your condition to the health care provider.
- Report to the health care provider whether you understand a planned course of action and what is expected of you.
- Understand that contraband is not permitted on hospital premises (including guns, knives, or other weapons, illegal or unauthorized drugs or alcohol), and to not possess or use such contraband at UF Health.
- Follow the treatment plan recommended by the health care provider.
- Keep appointments and, when unable to do so for any reason, notify the health care provider or health care facility.
- Be responsible for your actions if you refuse treatment or do not follow the health care provider's instructions.
- Assure the financial obligations of your health care are fulfilled as promptly as possible.
- Ensure that your behavior while on UF Health premises does not harass, intimidate, or physically harm UF Health visitors, staff, and/or patients.
- Notify the health care provider of any advance directive(s) you may have executed.
- Be respectful of the property of other persons and of the hospital.

** it is the policy of UF Health to honor all appropriately completed Advance Directives.*

*** Agency for Health Care Administration / 2727 Mahan Drive / Tallahassee, FL 32308 / (888) 419-3456 or Joint Commission on Accreditation of Healthcare Organizations / Office of Quality Monitoring / One Renaissance Boulevard/ Oakbrook Terrace, iL 60181 / 800.994.6610*