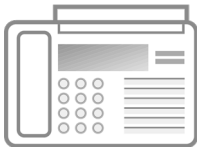
F A X

Company Name
Street Address
City, ST ZIP Code
Phone
Website



To: UF Behavioral Health Hub
Fax number: 352-627-4161

From:
Fax number:

Date:

Regarding:
UF BH HUB CONSULT REFERRAL

Phone number for follow-up:
352-265-2252

Comments:

Please send an email to Keisha Thornton (keishathornton@ufl.edu) and copy Kati Breton (kbreton@ufl.edu) to alert them the consult referral packet has been faxed. Do NOT include any PHI in the email. Receipt will be acknowledged within two business days.

Thank you!!

University of Florida • Department of Psychiatry • Division of Child & Adolescent Psychiatry
North Central Florida Behavioral Health Hub Patient Referral/Staffing Form

TO BE COMPLETED BY REFERRING PRACTICE:	
Patient Information	
Date:	
Primary Care Practice & Contact Info:	
Referring Provider:	
Patient Name:	
Patient DOB/Age:	Ethnicity:
Patient Gender:	Insurance:
	Policy#/Grp#:
	Subscriber name/DOB:
Primary DX:	Additional DXs:
Medication List:	
PSC-17 Scores: I= E= A=	
Other Screener(s):	Scores:
Discussion w/family re. Hub: Y/N	Date:
Reason for Consult: (please specify)	**Documentation Needed:** 1. Release of Information (ROI) 2. Bio-psychosocial history (BPSA) 3. Current clinical note to indicate reason for referral 4. Any Psych eval or assessment 5. Scored PSC-17 + all completed screeners (i.e. PHQ-9, GAD-7, SNAP-IV) 6. Court order of guardianship (if needed)
TO BE COMPLETED BY HUB:	
CAP Assignment-Circle	
Dr. Pumariega	
Dr. Andrews	
Directive-Circle	
Doc-to-Doc	
Live Evaluation- televideo	
Post Doc Assignment-Circle	
Post Doc	Post Doc Name:
Directive-Circle all that apply	
90791	
Therapy Referral: Y/N	Input BHO:
Additional scales needed: Y/N	List Screener(s):
Notes:	

Dear Parent, Guardian and Caregivers:

Your primary care provider (PCP) is initiating a consult referral to the University of Florida, Department of Psychiatry, Division of Child & Adolescent Psychiatry, Behavioral Health Hub on behalf of your child.

Completion of the attached Bio Psychosocial intake form will provide our team with valuable background information and history to help us provide advice to your child's primary care provider (PCP) regarding your child's behavioral health needs. This information will serve as a compliment to the screener(s) that your provider has administered. Your child's PCP will share our recommendations and advise during an upcoming clinic visit.

Please take the time to complete this form in your provider's waiting area and return to the front desk staff prior to your departure.

Thank you for taking the time to complete the form and taking an active role in your child's behavioral health care!

UFHealth
UNIVERSITY OF FLORIDA HEALTH

University of Florida
Department of Psychiatry
Division of Child & Adolescent Psychiatry
North Central Florida
Behavioral Health Hub
352-265-2252

Mental Health Background Information

DEMOGRAPHICS:

Name of the person completing this form:

_____

Relationship to the child:

_____

Child's Full Legal Name: _____

Is there another name the child prefers being called? _____

Child's Date of Birth:_____/_____/ _____

Age: _____

Gender: _____

Race: _____

Religion: _____

Is the child adopted? No Yes
If yes, are they aware? No Yes

Who lives in the same household as the child?

Name	Sex	Age	Relationship to Child

What are the main concerns that you have about your child's behavior or emotions?

How long have you had these concerns?

Traumatic experiences: Has your child ever been exposed to actual or threatened death, serious injury, or sexual violence? No Yes

Please list any symptoms related to the traumatic event?

PAST PSYCHIATRIC HISTORY:

Has your child ever seen a **psychiatrist or therapist/counselor** before?

Name of provider	Dates seen	Reason

Has your child ever been admitted to a **psychiatric hospital**?

Name of the hospital	Dates	Reason

Has your child ever attempted suicide? No Yes If yes, please describe:

Does your child engage in any self-harm behaviors (like cutting)? No Yes If yes, please describe:

Has your child ever been violent or aggressive? No Yes If yes, please describe:

FAMILY HISTORY:

Please list any known psychiatric illnesses in **blood relatives** of the child:

Psychiatric illness:	Child's Mother	Child's Father	Child's siblings	Mother's side of the family	Father's side of the family
Depression					
Anxiety					
Bipolar disorder					
Psychosis					
Schizophrenia					
ADHD					
Intellectual disability or learning problems					
Autism					
Eating disorder					
Alcohol problems					
Drug problems					
Suicide					

SUBSTANCE USE HISTORY:

Does the child use: Alcohol Tobacco Illegal drugs

Specify: _____

MEDICAL HISTORY:

Does your child have any history of the following medical conditions *(circle all that apply)*?

Allergies (describe)	Loss of Consciousness
Asthma	Heart problems
Respiratory Illness	High Blood Pressure
Diabetes	Low Blood Pressure
Convulsions/Seizures/Epilepsy	Urogenital Problems
Head Injury	Vision Problems
Dizziness or Fainting	Hearing problems

List any other serious illness or disease _____

Has your child ever had surgery? No Yes
If yes, describe and give dates:

Has your child ever had any serious injuries? No Yes
If yes, describe and give dates:

Biological females only:
Has your child started menstruation? No Yes
If yes, at what age _____
Are periods regular? No Yes

MEDICATIONS:

Please list all medication your child is **currently taking**:

Name of medication	Dose of medication	Who prescribes it?

Please list any medications your child has **taken in the past**:

ALLERGIES: No Known Drug Allergies Other:
Please list any allergies: _____

SOCIAL HISTORY:

Name of current school:_____
Current grade: _____
Did the child repeat any grades? No Yes _____
Does the child have a 504 plan or IEP? No Yes _____
Is the child in ESE or special needs classes? No Yes _____
Who all lives together in the household? _____

DEVELOPMENTAL HISTORY:

Has anything significant occur during the child's development years?

_____

TESTING HISTORY:

Any history of IQ or achievement testing? No Yes _____
Ever been tested for hearing abnormalities? No Yes _____
Ever been tested for speech/ language abnormalities? No Yes _____
Has the child ever received occupational or physical therapy? No Yes _____

OTHER: Has the child experienced any of the difficulties below? Please circle all that apply:

Death of a parent, Death of other loved ones/close friend, Separation from parent or family, Parent separation/divorce, Loss of Home, Family financial problems, Parent with substance abuse problem, Conflicts with parents, Removal of child from home, Victim of crime or violence, Unwanted pregnancy, School problems, Illness in self, Illness in family (specify), Other:

Please elaborate on any of the above and how they have affected our child:

ENTER PCP NAME/PRACTICE HERE

Dear Families,

Due to the great shortage of child mental health professional in our region, we have entered into an agreement with the University of Florida, Department of Psychiatry, Division of Child and Adolescent Psychiatry. This agreement, called a Behavioral Health Collaborative, provides our practice with consultation and advice on how we can best deliver mental health services for your child, and obtain assistance on referrals for counseling therapy services. We will have consultation from child & adolescent psychiatrists, psychologists, and a licensed clinical social worker (LCSW). When you provide written consent, we will submit a consultation request to the Collaborative to help your child. There are several steps that will occur as a result, all of which are essential and necessary to deliver these enhanced services:

- You may be contacted by the LCSW or Post Doc from UF Department of Psychiatry to obtain important information from you and your child. This assessment will be phone or televideo (via Zoom) and takes about 20 minutes. It is essential to have this information to provide consultation to your child's primary care provider (PCP). Please collaborate on scheduling and making this contact a priority to expedite the consultation.
- If your child has received services for behavioral health services by another provider, you will be asked to sign release of information permissions to obtain prior records, and possibly retrieve them in person if necessary. It is very important we can review all this information so we can make appropriate recommendations for your child's care.
- Your Primary Care Provider from our office will have a telephone conversation with the Psychiatrist or Psychologist to discuss your child's needs; this is referred to as a "doc-to doc" consultation. During this conversation the Psychiatrist/Post Doc will make recommendations to your primary care provider regarding his/her treatment. Most of our work is accomplished through such consultation. Your child's PCP will relay these recommendations during your next visit, or sooner if warranted.
- In some cases, you and your child may be asked to participate in a 60-minute telehealth evaluation via Zoom with a Psychologist or Psychiatrist, either direct to your home or to an exam room at our office. Based on this telehealth appointment, the psychiatrist will communicate recommendations to your child's primary care provider.
- If it is deemed appropriate, your child may be referred for therapy at local or regional mental health services and the LCSW or Psychologist will help with that referral.
- The level of service delivered is determined by mutual agreement between our team and your child's PCP, taking into consideration the family's input. However, it is totally up to you to decide participation by your child's PCP in this consultation program.

We are committed to the care of your child and strive for the best possible outcomes with his/her care. Likewise, your participation in the collaborative is also a commitment on behalf of your child.

[Phone]
[Email]
[Website]
[Street Address, City, State, Zip Code

Child ID#: _____ Child age _____

Caregiver: _____ Date: _____

Pediatric Symptom Checklist-17 (PSC-17)

INSTRUCTIONS*:* Emotional and physical health go together in children. Because caregivers are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

	Please mark under the heading that best fits your child			***For Office Use***		
Does your child:	**Never**	**Sometimes**	**Often**	**I**	**A**	**E**
1. Feel sad.	☐	☐	☐			
2. Feel hopeless.	☐	☐	☐			
3. Feel down on him/herself.	☐	☐	☐			
4. Worry a lot.	☐	☐	☐			
5. Seem to be having less fun.	☐	☐	☐			
6. Fidget, is unable to sit still.	☐	☐	☐			
7. Daydream too much.	☐	☐	☐			
8. Distract easily.	☐	☐	☐			
9. Have trouble concentrating.	☐	☐	☐			
10. Act as if driven by a motor.	☐	☐	☐			
11. Fight with other children.	☐	☐	☐			
12. Not listen to rules.	☐	☐	☐			
13. Not understand other people's feelings.	☐	☐	☐			
14. Tease others.	☐	☐	☐			
15. Blame others for his/her troubles.	☐	☐	☐			
16. Refuse to share.	☐	☐	☐			
17. Take things that do not belong to him her.	☐	☐	☐			
TOTAL						

To Score:

Fill in the unshaded box on the right: "Never" = 0, "Sometimes" = 1, "Often" = 2.

Sum the columns.

PSC17-Internalizing score is the sum of column I.

PSC17-Attention is the sum of column A

PSC17-Externalizing is the sum of column E.

PSC-17 Total Score is the sum of PSC17-I + PSC17-A + PSC17-E.

Positive Scores:

PSC17-I	≥ 5
PSC17-A	≥ 7
PSC17-E	≥ 7
Total Score	≥ 15

PSC 17 Gardner W, Murphy M, Childs G et al. (1999)

Record Request: Authorization to Use and Disclose Protected Health Information ("PHI") Maintained by UF Health*

**For purposes of this agreement, 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.*

Patient's Name	Date of Birth	Medical Record #
Patient's Address / City / State / Zip		
Phone #	☐ Check if patient is an employee of UF Health Shands	

By signing this form, I authorize the release of PHI (i.e., medical records) as follows:

From the doctor, office, facility of other health care provider checked or written below:	**To the facility / person below:**
☐ **Specialty, Physician or Hospital:**	☐ **Check here if same as patient** ☐ **Check here for records pick-up only**
Clinic, person or organization	Clinic, person or organization
Address	Address / Fax
Phone / Attn	Phone / Attn

Please check appropriate facility and mail or fax completed forms to:	**UF Health HIM Dept – ROI** P.O. Box 100348 Gainesville, FL 32610-0348 Phone: 352.594.0909 Fax: 352.265.1098	☐ **UF Health Shands Hospital** ☐ **UF Health Shands Rehab Hospital** ☐ **UF Health Shands Psychiatric Hospital** ☐ **UF Health Florida Recovery Center**	☐ **UF Health Clinics** ▪ Specific Clinic: ☐ **UF Health Shands HomeCare** 1610 NW 23rd Avenue, Gainesville, FL 32605 Phone: 352.265.0789 ▪ Fax: 352.265.9276

The following PHI may be released *(check boxes below)*:			**I further authorize the release of the following information which may be included in the PHI:**
☐ History and Physical	☐ Operative Report(s)	☐ Discharge Summary	☐ Behavioral Health
☐ Problem List	☐ Medication List	☐ Clinic/Office Notes	☐ Substance Use Disorder
☐ Emergency Room Record	☐ Radiology Reports	☐ Lab/Pathology Reports	☐ STD/HIV/AIDS Treatment(s) or Test(s)
☐ Billing Records	☐ Radiology Images	☐ Other:_____	☐ Genetic Testing
Is this needed for a doctor's appointment?	Write date below:	**Are there specific dates needed?**	Write dates below:

Purpose of this request?	☐ Treatment/Continued Care ☐ Payment/Billing ☐ Personal Use ☐ Legal ☐ Other: _____
Format of Records?	☐ MyUFHealth (UF Health Portal) ☐ CD ☐ Paper

This authorization allows UF Health to use and disclose (release) certain PHI, which includes medical records, as I have directed.

I understand that:

- The PHI may include information about mental health, substance and/or alcohol use, HIV/AIDS, and STDs.
- I understand that substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Records, 42 C.F.R. Part 2, and HIPAA, 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by these regulations.
- This authorization may be used to share the same type of PHI indicated above which may be created in the future, until the expiration date.
- This authorization will remain in effect for **one (1) year** or until I revoke it in writing (i.e., tell UF Health to cancel it).
- I have the right to revoke this authorization at any time.
- I understand that I must revoke this authorization by writing to the Health Information Management Department at the organization named above and that the revocation will not apply to action already taken as a result of this authorization.
- I may refuse to sign this authorization and doing so will not affect my treatment, payment, enrollment, or eligibility for benefits or the quality of care that I will receive.
- I understand that PHI released per this authorization may no longer be protected by state law or the federal health privacy law and could be redisclosed by the person or entity that receives it.
- I am aware that I may be charged a fee for this request as allowed by law, which may include up to $1.00 per page (plus applicable tax and handling) for Paper Records and fees associated with labor, supplies (i.e. cost of a computer disk), and postage for Electronic Records. Fees are waived when PHI is released to a health care provider for treatment purposes.

_____ _____

Signature of patient / patient representative **Date**

Complete the section below *only* if the person requesting records is not the patient:		
Name of Representative	Relationship to Patient	Legal Authority
Representative's Address & Phone Number	Verification of Identity (Internal use only)	Verification of Authority (Internal use only)

UFHealth SHANDS UF UNIVERSITY of FLORIDA

Authorization for Use or Disclosure of Protected Health Information

Revised 5/30/19
PS46283

RI0001

***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., The Villages® Tri-County Medical Center, Inc., Leesburg Regional Medical Center, Inc., and Shands Recovery, LLC. Collectively, these entities are referred to as UF Health in this form.**

Consent and Authorization for Treatment – I consent to and authorize UF Health*, my physicians and health care providers (collectively "my providers") to provide or order the medical care, diagnostic and laboratory procedures and prescribe medicinal drugs, 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, research 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; researchers, or entities engaged in research; 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 and/or research 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.

I understand that my patient information is protected by the right to privacy guaranteed by Article 1, Section 23 of the Florida Constitution. I do not authorize the release of my patient information, including the release of information with my name or identifying information redacted, if requested by other patients or their representatives.

Medicare Request 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) I 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 authorize UF Health to share PHI and PII with its affiliated vendors and vendors' affiliates. I consent to UF Health or any third party contacting me by email, telephone, including my cellular phone and including auto dialed calls and/or pre-recorded messages and text messages, 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 on next page)

Patient Name:

Date:

Medical Record Number:

(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.; Shands Recovery, LLC; The Villages® Tri-County Medical Center, Inc., and Leesburg Regional Medical Center, Inc.. 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 to 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. I further acknowledge that if I am the parent of the minor patient, this written consent pursuant to Section 1014.06, Fla. Stat., shall be ongoing and remain in effect until revoked by me. Further, I authorize my providers to contact me via telephone to discuss any condition, diagnosis, care or treatment that may be covered by this written consent for any subsequent medical care or treatment and this document be deemed as my written consent, if such care is discussed, related to any future treatment by my providers.

PATIENT/GUARDIAN	DATE	INSURED (If other than the above for assignment of benefits, e.g., step-parent)	DATE
AUTHORIZED REPRESENTATIVE (Patient unable to sign)	DATE	WITNESS (Print Name)	DATE
GUARANTOR (Spouse, Partner, etc.)	DATE	WITNESS (Signature)	DATE

NOTICE OF LIMITED LIABILITY

PURSUANT TO SECTION 1012.965, 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 JACKSONVILLE MEDICAL CENTER, INC., d/b/a UF HEALTH JACKSONVILLE, SHANDS TEACHING HOSPITAL AND CLINICS, INC., d/b/a UF HEALTH SHANDS HOSPITAL, THE VILLAGES® TRI-COUNTY MEDICAL CENTER, INC., d/b/a UF HEALTH THE VILLAGES HOSPITAL, LEESBURG REGIONAL MEDICAL CENTER, INC., d/b/a UF HEALTH LEESBURG HOSPITAL, AND 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 JACKSONVILLE MEDICAL CENTER, INC., d/b/a UF HEALTH JACKSONVILLE, SHANDS TEACHING HOSPITAL AND CLINICS, INC., d/b/a UF HEALTH SHANDS HOSPITAL, THE VILLAGES® TRI-COUNTY MEDICAL CENTER, INC., d/b/a UF HEALTH THE VILLAGES HOSPITAL, LEESBURG REGIONAL MEDICAL CENTER, INC., d/b/a UF HEALTH LEESBURG HOSPITAL, AND SHANDS RECOVERY, LLC, (collectively "SHANDS") FACILITY ARE NEITHER EMPLOYEES NOR AGENTS OF SHANDS.

Printed Patient Name _____

Patient/Parent/Guardian _____ Date _____

Patient Rights and Responsibilities

You have the right to:

- Respectful care that is free from discrimination on the basis of race, color, national origin, religion, age, sex, physical, mental or other disability, medical condition, sexual orientation, gender identity, gender expression, pregnancy, marital status, citizenship, veteran status, source of payment or other non-medically relevant factors.
- Privacy and confidentiality.
- Know what patient services are available to you and receive financial counseling so you may meet financial obligations.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- Be called by your preferred name and pronouns.
- Know which rules apply to you.
- Know who is providing your medical services and who is responsible for your care.
- Be provided sign language or medical interpreter services if you have a need at no charge to you.
- Be informed of available pastoral services and be visited by a chaplain upon request. You may also be visited by your own spiritual leader.
- Upon request have your primary care provider notified of admission to the hospital.
- Have visitors. Visitation may be limited in accordance with reasonable restrictions based on safety and security.
- Discrimination in visitation access based on marital status, sexual orientation, gender identity, gender expression, race, national origin or religion is prohibited.
- Have someone remain with you in patient-accessible areas for emotional support during your hospital stay (unless your visitor(s) compromises other patients' rights to safety and health).
- Receive a careful evaluation, followed by polite and prompt treatment.
- Receive a reasonable response to a question or request.
- If it is safe for you to participate, be given the choice to watch certain procedures.
- Have your pain assessed and reduced as much as safely possible with pain management.
- Receive information and instructions in ways that you understand. Your doctor will inform you about your diagnosis, planned course of treatment, any alternatives, the risks and benefits of any treatments, the prognosis, and the expected and unexpected outcomes of any treatment, unless it is medically inadvisable or impossible to give this information to you. You may refuse treatment which shall be documented by the medical provider and be informed of the medical results of this decision.
- Please talk openly with your doctor regarding:
  - Your illness
  - The reason for provided treatment and tests, who does them and who will share the results of those treatment or tests with you
  - Your wish for a second opinion from another doctor
  - Your wish to change doctors and/or hospitals
  - Your right to request an ethics consult from Ethics Service
- Receive treatment for any medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such research.
- Receive an explanation of all papers you are asked to sign and upon request receive an itemized bill or statement of charges.
- Express complaints regarding any violation of your rights
- If you are a Medicare patient, upon request and in advance of treatment you have a right to know whether the Medicare assignment rate is accepted and you have the right to receive a "Notice of Beneficiary Discharge Rights," "Notice of Non-coverage Rights" and "Notice of the Beneficiary Right to Appeal Premature Discharge."

You are responsible to/we ask that you:

- Provide health care team accurate and complete information about your health including your present complaint, past illnesses, hospitalizations, medication and other matters relating to your health.
- Inform the care team if you understand the plan for your treatment.
- Keep appointments.
- Meet the financial responsibilities associated with your care.
- Follow the care recommended by your health care team members. You are responsible for the risks and outcomes if you do not follow provided instructions or refuse treatment.
- If you leave the hospital against the advice of your provider, the hospital and providers will not be responsible for any health consequences that may occur.
- Respect the rights of other patients, families and hospital staff.
- Keep a quiet restful environment because rest is an important part of healing.
- Follow hospital rules and regulations that apply to patient conduct.
  Such as:
  - Not smoking on hospital grounds.
  - Acting with respect for hospital property.
  - Refraining from the use of inappropriate language such as cursing or swearing.
  - Refrain from behavior and language that threatens patients, families and staff with bodily injury, fear and intimidation.
  - Please do not use words, actions or behaviors that are threatening to oneself or others.
  - This includes words, actions or behaviors that reflects an intention to instill fear in another person or the intent to cause physical or mental harm that could lead to psychological or physical harm of another person.
- Report unexpected changes in your condition to the responsible caregiver.
- If you feel your concerns about your clinical care are not being addressed you have the right to call condition H.

If you have any concerns about your Patient Rights and Responsibilities, please call the Patient Advocate Office at 352.265.0123.
If you have a complaint and wish to file a grievance you may contact the Patient Advocate Office or you may also contact the following agencies:
***Agency for Health Care Administration / 2727 Mahan Drive / Tallahassee, FL 32308 / 888.419.3456 or Joint Commission / Office of Quality Monitoring / One Renaissance Boulevard / Oakbrook Terrace, IL 60181 | 630.792.5636 (F)*