***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., UF Health Spanish Plaines Hospital; 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.

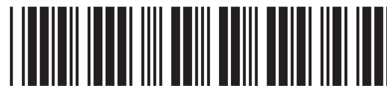
I understand that my patient information is protected by the right to privacy guaranteed by Article 1, Section 23 of the Florida Constitution. I do not authorize the release of my patient information, including the release of information with my name or identifying information redacted, if requested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



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***If printed, all pages must be stapled.***

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; UF Health Spanish Plaines Hospital, 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.

**Hospital Quality Measures/Patient Information** – I acknowledge that I have been provided access to UF Health facility's AHCA Hospital Quality form. Visit UFHealth.org/quality-and-patient-safety#hospital-quality-measures-patient-safety-information for form.

**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, UF HEALTH SPANISH PLAINES 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, UF HEALTH SPANISH PLAINES 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 ______________

*If printed, all pages must be stapled.*

Patient Name:

Date:

Medical Record Number:

## 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.*