PATIENT CONSENT AND ACKNOWLEDGMENT

This is a Lifespan Standard Patient Consent and Acknowledgement used when registering patients at any Lifespan Affiliated Hospital (Newport, Rhode Island, and The Miriam), their Clinics, or the Lifespan Physician Group Practice sites ("Care Sites").

CONSENT TO EXAMINATION AND TREATMENT - I understand that I may require examinations, medical and diagnostic procedures, medications, and in some instances, additional therapies, in connection with the diagnosing and treatment of my medical condition. I further understand that tissue and biologic fluids such as blood or urine may be collected in that examination and diagnosing process, and that they may also use such specimens for diagnostic, education, quality improvement, scientific or certain research purposes. I understand that during my care, I may be examined and treated by physicians and other personnel as part of their supervised training. I further understand that photographs, videotapes, audiotapes, digital or other recordings may be taken for identification purposes or to document my medical condition or care. I hereby consent to the performance of such examinations and procedures as part of my treatment, as may be deemed appropriate by the clinicians providing care to me (the "Care Team").

I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me about the effectiveness of any procedures, treatments, or examinations. I understand that I have the right to withhold consent to any medical or surgical procedure. I further understand that my Care Team will inform me about what is the most reasonable course of action for my condition, and that such a course of action will be identified and taken with my best interest as a patient in mind. I understand that the Care Site has the right to decline to perform any procedure if I, or my representative(s), have not clearly provided an informed consent. I realize that if I, or my designated representative(s), withhold consent for a recommended procedure, that treatment may be rendered partially or wholly ineffective.

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION TO PROVIDER - I understand that physicians on staff at a certain Care Site may not be employees of that particular Lifespan Care Site. I hereby authorize payment of my health insurance benefits directly to the applicable Lifespan entity and to any Lifespan affiliated physician rendering services during this hospitalization or visit. I understand that I am responsible for charges not covered by my insurance company and I understand it is my responsibility to meet the contract requirements of my health plan. I understand I may receive separate bills from services providing emergency care, interpretation of x-rays and other diagnostic imaging, and that some physicians' services may be billed separately from the Care Site services.

MEDICARE AUTHORIZATION - To the extent I am covered by Medicare, I agree to the conditions of admission for hospitalization outlined in this agreement. I certify that all the information I provided in connection with my application under the Medicare Program (Title XVIII of the Social Security Act) is correct. I request that payment for any authorized Medicare benefits to be made on my behalf be made to the hospital or its employed physicians. I authorize any holder of medical information or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine my entitlement to these Medicare benefits or benefits for related services.

FINANCIAL RESPONSIBILITY - I agree, in order for Lifespan to service my account or collect any amounts I may owe, Lifespan may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

I authorize the Care Site to apply any outstanding credit balance I may have on my account to satisfy to the fullest extent possible any outstanding account balance(s) I may have with a different Care Site before processing any patient refund to me.

ACKNOWLEDGMENT - I certify that I have read the above and that it has been explained to me so that I understand it. I certify that I am the patient, the patient's parent/guardian, or a duly authorized patient representative, able to review the above terms and accept them.

If I am registering for, or as a result of my care, receive drug or alcohol (substance use disorder-related) treatment at one of the following programs: Caritas House (at Bradley Hospital), Batterers intervention program, Eastman House or Pawtucket Addictions Counseling Services (at Gateway Healthcare) and/or Psych Adult Medicine Treatment Center (at Lifespan Physician Group Practice), I am also being asked to extend my acknowledgement and consent to the following statements:

Patient Name: _____ Medical Record# _____ HAR# _____

CONSENT TO A LIFESPAN (42 CFR PART 2) PROGRAM TO DISCLOSE MY DRUG/ALCOHOL TREATMENT INFORMATION - I consent to allow that Lifespan program to disclose all my substance use disorder-related claims and encounter data including but not limited to my history, diagnosis, medication, treatment and other such identifying information to my LifeChart record (my electronic health record at Lifespan) and to my treating providers and professionals who are authorized to access my LifeChart record, whether or not they practice at a Lifespan affiliate. This consent will expire if and when Lifespan, or its successor organization, and LifeChart or its successor electronic medical records system, no longer exist. I understand that I may revoke this consent in writing with notice to the Lifespan program(s) where I have obtained drug or alcohol treatment at any time. I also understand, however, that I cannot withdraw my consent for disclosures that have already been made in reliance on my original consent.

I also understand my right to request a list of entities to which my drug or alcohol treatment information has been released by my Lifespan treating program(s) pursuant to this consent. I understand that I am only entitled to this list of entities to which disclosures have been made in the two years prior to my request.

By signing this consent form below, I acknowledge that I understand this consent form and that it means my treatment information which is protected under the federal confidentiality regulations at 42 CFR Part 2 can be released to my LifeChart record and accessed by my treating providers and professionals.

If I am registering to be, or as a result of my care am made, an Inpatient of one of the following institutions: Newport Hospital, Rhode Island Hospital or The Miriam Hospital, I am also being asked to extend my acknowledgement and consent to the following statements:

RIGHT TO ADVANCE DIRECTIVES - I have been given written information on my right to make medical decisions and to have advance directives (in the form of a living will or Durable Power of Attorney for Health Care). I understand that it is my responsibility to provide my Care Team with a copy of my advance directive, and that failure to do so may mean my wishes are not known to my providers. I understand that my advance directive will be handled with appropriate sensitivity and confidentiality and that I will be provided with the same quality of care whether or not I have an advance directive.

PERSONAL BELONGINGS - I understand that Lifespan cannot be responsible for my personal belongings. I have left my valuables home, or I am assuming the risk of loss if I have brought them with me to the Lifespan hospital/affiliate.

PERSONAL ELECTRONIC DEVICES - I understand that the use of personal electronic devices by patients and/or visitors for the purposes of taking and/or transmitting photographs, video recordings, or audio recordings, of patients, medical staff, or hospital employees, is prohibited.

ELECTRONIC COMMUNICATIONS – I agree to the receipt of electronic communications of an administrative nature from Lifespan. Methods of transmission might include emails, text messages, phone messages, and other electronic means that might become available. The purpose of these communications might include but shall not be limited to appointment scheduling or reminders, notifications concerning the MyLifespan patient portal, program registrations, surveys, general inquiries, or billing/payment issues. By agreeing to these transmissions, I acknowledge that the privacy and security of electronic communications cannot be guaranteed and that parties with whom I have chosen to share electronic addresses or phone numbers may be aware of such transmissions and may have the means to access my personal health information using information from these transmissions.

ACKNOWLEDGEMENT OF NOTIFICATION SECURITY CAMERA USE - I understand that security cameras are in place in certain public areas of the hospital including some patient areas.

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PATIENT (or PATIENT'S GUARDIAN / AGENT / REPRESENTATIVE)

Signature: _____ Date: _____ Time: _____

(Print Name) _____