



COND TREAT

CONDITIONS FOR TREATMENT AND FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

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Any reference to "ChristianaCare" in this consent means the ChristianaCare hospitals and its employed medical providers. Unless I otherwise withdraw my consent in writing, I agree and consent to the following terms as conditions for treatment received by me and/or by my minor child and/or ward from ChristianaCare:

CONSENT FOR TREATMENT

- A. ChristianaCare may obtain my health and insurance coverage information, including my healthcare treatment and prescription history, and provide health services to me. I understand and agree that there is no guarantee of any specific outcome of healthcare services provided. I understand this consent applies to inpatient and outpatient hospital-based services performed at any ChristianaCare location or in the home settings, as well as all ambulatory office-based services received by me or my child and/or ward from ChristianaCare.
- B. I consent to ChristianaCare sharing my information with other providers of care for professional consultation for services.
- C. ChristianaCare is a teaching institution and professional trainees may participate in care for me and/or my child or ward.
- D. ChristianaCare may use photographic, video, electronic, or audio media during or as part of some treatments (e.g., trauma, infant resuscitation) for performance improvement, patient identification, training and/or treatment purposes and this may be recorded. I understand that these recordings may be reviewed by the healthcare professionals but will not become a part of the medical record and will be erased after review.

TELEHEALTH

- A. I understand that "telehealth" (which includes "teletherapy" and other behavioral health services) is the mode of delivering health care services using digital communication technology to help evaluate, diagnose, consult, educate, monitor, and manage care and treatment without being in the same physical location as my provider.
- B. I understand that a telehealth visit is not the same as an in-person visit because the provider of care is not in the same room as me and/or my child or ward. I understand that the quality of the digital connection may affect my provider's ability to care for me through telehealth. I understand that I and/or my child or ward will not be treated through telehealth unless the condition of me and/or my child or ward supports the use of this technology as my provider will not be able to perform some aspects of a full physical examination.
- C. I understand that digital communication technology may include, but not be limited to real time two-way audio, video, or other telecommunications or electronic communications, including remote patient monitoring, secure video conferencing, and/or secure texting with the care team.
- D. I understand that there are benefits to utilizing telehealth services, which include, but are not limited to, convenient medical evaluation and management. I also understand that there are risks involved in receiving treatment through telehealth, which include, but are not limited to interruption in the audio/video connection that may result in the visit being postponed until a later time and/or performed through an alternate method, and, in rare cases, unauthorized access to my confidential information. I understand that while I am, and/or my child or ward is, receiving care through telehealth, my provider may not be able to help modify or address issues with my location or environment that may interfere with the receipt of telehealth services. In the event of a technical failure, I understand that I should immediately contact my provider's office, or, if it is an emergency, dial 911.
- E. I understand that laws protecting the confidentiality of my medical information and/or that of my child or ward also apply to telehealth and that ChristianaCare uses security protocols to help protect my privacy, and/or the privacy of my child or ward, and ensure the confidential communications are sent only to the intended care team member(s).
- F. I understand that ChristianaCare will not record the video or audio of the telehealth visit without my consent at the time of the recording.
- G. I consent to have ChristianaCare obtain health information from me and provide health care services to me and/or my child or ward through telehealth communications when and where my provider or qualified member of my care team determines it is appropriate and necessary.
- H. I understand that my provider, and/or the provider of my child or ward, may collaborate with other professionals in the delivery of telehealth services, the same as an in-person visit. I understand that as with in-person visits, the provider may not be aware of all of collaborating professionals' knowledge, experiences, and qualifications. I understand that under such circumstances the provider will use the same professional judgment and skill when working with other professionals as during an in-person visit.
- I. I understand that as with in-person visits, the provider may have other persons present with them to assist with the telehealth visit. The provider has informed me of all persons who will be present with them during the telehealth visit, the role of each person, and I consent to my provider sharing my health information and/or the health information of my child or ward in their presence.
- J. I understand that as with in-person visits, other individuals whom I choose to have present during my telehealth visit may hear my health information and I consent to my provider sharing my health information in their presence.
- K. I understand that I may refuse or stop participation in telehealth services and request alternate services, such as an in-person visit, at any time.

RELEASE FROM LIABILITY FOR VALUABLES

- A. I am responsible for loss or damage to personal property brought to a ChristianaCare facility, except for belongings placed in the hospital's safe. I release ChristianaCare from all claims for lost, stolen or damaged property.
- B. If I am hospitalized, I agree that the maximum liability of the hospital for loss of any belongings placed in the hospital safe is limited to \$300 unless the hospital gives me a written receipt for a greater amount.

FINANCIAL RESPONSIBILITY

- A. Except as provided herein, I agree that I am financially responsible to ChristianaCare and to non-ChristianaCare providers for all charges for healthcare services provided to me and/or my child or ward during my visit. Non-ChristianaCare providers include, without limitation, non-pediatric Emergency Department physicians, anesthesiologists and non-pediatric obstetricians.
- B. In the event the services are covered under a commercial and/or government health plan, then I may only be responsible for co-pays, co-insurance and/or deductibles, if any, under these plans. If I am not covered by Medicare, Medicaid and am not a self-pay patient, I have been offered the opportunity to review the No Surprises Act (Balance Billing) Disclosure.



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FINANCIAL RESPONSIBILITY (continued)

- C. If the services are not covered under a commercial and/or government health plan, then I am responsible for all charges.
D. If the services are provided in the same state in which I am, and/or my child or ward are covered by that state's Medicaid plan, then I am not financially responsible for healthcare services provided by ChristianaCare.
E. I understand that ChristianaCare only recognizes commercial and/or government health care plans as insurance coverage and does not recognize cost sharing programs as commercial insurance coverage.
F. I understand that if I am not covered by a commercial insurance or government health plan, I and/or my child or ward will be considered a self-pay patient.
G. Enforcement. If any collection or other legal action is brought for the enforcement of payment of patient financial responsibilities for health care services provided by ChristianaCare, then I am responsible to pay ChristianaCare for all costs, including collection fees and attorneys' fees incurred in that action or proceeding, in addition to any other relief to which the ChristianaCare may be entitled.

ASSIGNMENT OF BENEFITS

- A. I assign payment of all insurance or other benefits, under which I am and/or my child or ward is entitled to coverage, to ChristianaCare, its healthcare contractors and related physician groups, as applicable, for healthcare services provided to me during my patient care visit. I specifically provide my consent effective with the date of my initial treatment and/or admission by ChristianaCare as the protective filing date to apply for Medicaid entitlement benefits to cover my medical treatment, with respect to my application for Medicaid coverage, in the event I need to apply for myself and/or for my child or ward.

MEDICARE ASSIGNMENT OF INSURANCE BENEFITS

- A. Where Medicare benefits apply, I confirm the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct. I request payment of authorized Medicare benefits to ChristianaCare and its contracted services and physician groups for any services I receive. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits for related services.

PATIENT COMMUNICATIONS

- A. I consent to ChristianaCare communicating with me by phone, email, or text message to the telephone number and/or email address provided by me. I recognize and understand that there is a risk of an unintentional disclosure of information, including my protected health information, to a third party, if information is sent via email or text message.
B. I consent and authorize ChristianaCare to use my email and telephone number for patient satisfaction surveys, delivery of healthcare information, visit follow up, advertisements, telemarketing purposes, billing matters and collections on an account.
C. I consent and authorize ChristianaCare to use my telephone number and email to communicate with (i) an automatic telephone dialer and/or (ii) pre-recorded calls and/or (iii) text messages.
D. I understand that I have a right to opt out of any and all patient communication methods mentioned above if contacted.
E. This consent applies to all past, present and future communications from ChristianaCare until I revoke this consent in writing.
F. I understand my Primary Care Physician will be notified of my admission to the hospital.

NOTIFICATION AND ACKNOWLEDGMENT OF FINANCIAL ASSISTANCE PROGRAM

I have been offered the opportunity to receive and review the "Financial Assistance Program Summary."

NOTICE OF PRIVACY PRACTICES

I have received a copy or have been given the opportunity to review the ChristianaCare "Notice of Privacy Practices."

CONSENT

I have read this document or it has been read to me and I understand my responsibility:

Patient/Representative Signature Date Time

Patient Representative Relationship to Patient

Telephone Number Email Address

Interpretation: The information has been presented to the: Patient Representative Decision Maker in: Language

Interpreter Name Agency and ID# (if applicable)

Witness Signature/Title Print Name or ID# Date Time