SHERIDAN MEMORIAL HOSPITAL
1401 W. 5th Street
Sheridan, WY 82801 (307) 672-1000

SHERIDAN MEMORIAL CLINICS
1333 W. 5th Street
Sheridan, WY 82801 (307) 675-2649

Name (last, first):
DOB: **Age:** **Sex:**
Attending:
FIN: **MRN:**

Conditions for Registration/Services/Admission

Consent for Treatment. I consent to healthcare services provided by Sheridan Memorial Hospital and associated Sheridan Memorial Clinics (hereinafter "SMH") such as laboratory procedures, radiology procedures, examinations, diagnostic procedures, and other hospital, medical, nursing, or surgical services that are deemed necessary or advisable by my attending, emergency, or consulting providers (radiologists, pathologists, anesthesiologists, nurse practitioners, physician assistants, and others) for myself and any children who are born to me at SMH. I understand there are risks associated with any healthcare service and that no guarantee or assurance has been made as to the results of any treatment or healthcare services provided to me. I understand that I have the right to refuse any test, treatment, or procedure, except in the case of an emergency. I understand that my medical care and treatment may be provided by physicians, physician assistants, nurses, and supervised clinical students. I understand that certain procedures at the hospital may be performed by outside providers who may bill me separately for these services. I authorize the presence of company representatives for specialized equipment or supplies in Surgery or other specialized areas. I consent to the use of photographs, videotapes, digital, or other images for purposes of identification, diagnosis, and treatment. I understand that SMH retains ownership rights to these images and recordings

E-Prescribe Authorization. I understand that SMH electronically sends prescriptions and can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes such as formulary and benefit transactions, medication history transactions, fill status notification, and others. I authorize SMH to release my healthcare information to share and/or receive prescription information with SureScripts (a national prescription

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database) utilized in electronically prescribing medication for my treatment.

Patient's Physicians. Not all physicians that provide me medical care and services at SMH are employed by SMH. I understand that those physicians who are independent contractors are not agents of SMH, and that SMH is not liable for the acts or omissions of any independent physicians.

Leaving Against Medical Advice: If I choose to leave SMH against or without the advice of my physician(s), I hereby release SMH, my physicians and SMH agents and employees from all liability for any ill effects that may result. I also acknowledge that I can be personally liable for all healthcare costs that I have incurred during my admission to SMH if I leave SMH against medical advice.

Release of Financial Information. I authorize SMH to disclose my medical and financial information to employees, agents, or third parties who provide billing, payment, or collection services. I consent to be contacted by SMH or any entity to which SMH assigns my account regarding any matter related to my account, including billing, payment, and collection.

Contact Information. I consent to receive communications by autodialed and prerecorded messages, text messages, email, regular mail, and direct communications regarding my healthcare and payment from SMH or any entity to which SMH assigns my account (including third party debt collectors) at the numbers (wireless and/or residential), emails, and addresses I provide. I also consent to receive satisfaction surveys to evaluate our customer service.

Assignment of Benefits and Promise of Payment: I assign SMH, and physicians or other healthcare providers who perform services for me during this visit, all benefits which are or shall become payable from any third party payer, including Medicare and Medicaid. I understand and agree that, even though I have assigned my benefits, I remain financially responsible for full payment of all medical care and treatment provided to me regardless of any nonpayment or reduced payment any of my third party payers determine to make on my behalf. Payment is due in full by me upon completion of services. If SMH submits any claim for services I have to a third party payer, it does so as an accommodation to me and does not

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thereby accept any terms, conditions, or limitations such third party payer may wish to apply. I agree to pay all collection expenses or attorney fees incurred in the collection of this account as a result of my failing to pay the same as agreed. I agree to pay an interest charge of 7% annual percentage rate on any unpaid balances. I understand that SMH reserves the right to assign my account with an unpaid balance for collection.

Medicare Authorization. If I am a Medicare beneficiary, I request payment of authorized Medicare benefits to me or SMH on my behalf for any services furnished and I understand that I am responsible for the payment of charges billed to me as permitted by Medicare.

Consent to Blood Test. I understand blood tests for communicable diseases such as hepatitis, HIV/AIDS and others may be performed upon me without my written consent if a healthcare professional or other SMH employee is exposed to my blood or other body fluids.

Patient Rights and Responsibilities. SMH acknowledges that you have certain rights as a patient, and I acknowledge that I have certain responsibilities as a patient. I acknowledge a written copy of SMH's Patient Rights and Responsibilities was provided to me upon admission to SMH hospital as an inpatient.

Notice of Privacy Practices. I understand that SMH may disclose my protected health information (PHI) for the purposes of treatment, payment, and operations as provided in the Notice of Privacy Practices. I acknowledge that a written copy of the Notice of Privacy Practices was provided to me upon admission to SMH as an inpatient.

Personal Valuables. I understand and acknowledge that SMH will not be liable for the loss or damage of any money, jewelry, glasses, hearing aids, dentures, prosthetic devices, documents, garments, or other articles, regardless of the article's value or size, unless such article is formally transferred to the care, custody and control of SMH as evidenced by issuance of a receipt. Without such receipt SMH shall not be liable for any loss or damage of any personal property. If personal items are not claimed within 60 days of discharge SMH may dispose of items.

Health Information Exchange. SMH participates in the electronic exchange

of PHI with other healthcare providers and health insurance plans through health information exchange (HIE) organizations. Through SMH's participation, your PHI may be accessed by other providers and health insurance plans, as permitted by law, for treatment, payment, and healthcare operations purposes. These HIEs maintain safeguards to protect the privacy of your PHI. You can opt-out of having your PHI accessed on these HIEs. Please contact Patient Access for information on how to opt out.

Telehealth: I may be offered medical care and services via telemedicine systems that involve the delivery of healthcare by electronic communication with a provider who is at a different physical location. I consent to initiating and/or receiving technology-based communications with my providers, including consulting services from a specialist performed virtually. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include encryption and other measures to safeguard the data and to ensure its integrity against intention or unintentional corruptions.

Telehealth possible risks:

- The information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Issues with technology used for telehealth may cause a delay medical evaluation and treatment.
- Rarely, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- Very rarely security protocols could fail, causing a breach of privacy.

With regard to Telehealth, I understand that:

1. Not all conditions are appropriate for diagnosis and treatment by telehealth and my healthcare provider will determine whether or not the condition I am seeking treatment for is appropriate for a telemedicine encounter.
2. Telehealth services have no direct, physical contact

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between a patient and Provider. Because of this, your provider may not be able to identify symptoms or to diagnose your problems at all or in a timely manner.

3. Telehealth services may not be covered by insurance and I may be required to pay out of pocket.
4. The quality of audio or video may affect the quality of services provided and may result in a disruption of care. Neither SMH nor the Provider are liable for these disruptions.
5. I may refuse to participate in telehealth in the course of my care at any time. My refusal does not affect my right to future care or treatment.
6. There is a potential risk of an equipment or technology failure which could result in an inaccurate diagnosis and I agree to hold SMH staff and providers harmless.

The undersigned has read and understands the Conditions for Services/Registration/Admission and accepts its terms. I verify that my e-signature represents my written signature.

_____

Patient's Signature Date Time

_____

Signature Relationship to Patient Date Time

_____

Witness Date Time