***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., and Shands Recovery, LLC. Collectively, these entities are referred to as UF Health in this form.**

Consent and Authorization for Routine Treatment – I consent to and authorize UF Health*, my physicians and health care providers (collectively "my providers") to provide or order the routine medical care, diagnostic and laboratory procedures, 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.

Pelvic Examination Consent: I understand that as a part of my medical care and treatment, a pelvic examination may be performed by my health care practitioner(s). In addition, I understand that a pelvic examination may be performed by a medical student, or any other student receiving training as a health care practitioner.

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 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; 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 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 consent to UF Health or any third party contacting me by telephone, including my cellular phone, for purposes of collecting any amounts owed by me.

(continued on next page)

If printed electronically, all pages must be stapled.

Patient Name:

Date:

Medical Record Number:

(continued)

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.

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.; or Shands Recovery, LLC. 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 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.

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 TEACHING HOSPITAL AND CLINICS, INC., SHANDS JACKSONVILLE MEDICAL CENTER, INC., OR 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 TEACHING HOSPITAL AND CLINICS, INC., SHANDS JACKSONVILLE MEDICAL CENTER, INC., OR SHANDS RECOVERY, LLC. (collectively "SHANDS") FACILITY ARE NEITHER EMPLOYEES NOR AGENTS OF SHANDS.

Printed Patient Name

Patient/Parent/Guardian | Date

UF | UNIVERSITY of FLORIDA

If printed electronically, 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, ancestry, marital status, citizenship, status as a veteran, ownership of a firearm, or other non-medically relevant factors.
- Expect certain rights to privacy and confidentiality without regard to economic status.
- Receive financial counseling so you may meet financial obligations and know what patient services are available to you.
- 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."
- Be called by your preferred names and pronoun.
- Know the name, function, and qualifications of the physician who has primary responsibility for coordinating your care, as well as the names and professional relationships of other providers, nurses and staff who will be involved in your care.
- Be provided sign language or medical interpreter services if you have a need at no charge to you.
- Have reasonable accommodations made for your religious or spiritual preferences.
- Upon request have your primary care provider notified of admission to the hospital.
- Have visitors.
- To ensure the safety of all of our patients your visitors under 14 years of age should be with an adult (who is not the patient) during the visit.
- Your visitors should be free from colds, flu, or any illness that might be spreadable.
- Reasonable restrictions are placed upon visitation, including restrictions upon the hours of visitation and number of visitors.
- Discrimination in visitation access based on sexual orientation, gender identity or gender expression 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, reasonable response to a question or request, and 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.
- If you suffer from severe chronic intractable pain, the doctor may choose alternatives to opiate medication, and can provide information about physicians who specialize in the treatment of severe chronic pain.
- 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
  - Why treatments and tests are done, 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
  - Ethical issues about your care
- 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
- 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 a Condition H.

You are responsible to/we ask that you:

- Provide your health care team accurate and complete information about your health.
- Share information about your health, such as a complete health history, symptoms, treatments, medicines, vitamins, supplements taken and any other information that could bear on your health.
- Be honest about what you tell us.
- Tell us about your health risks, such as allergies, or other risks that might impact your care.
- Give us copies of any legal documents that affect your healthcare, including any advance care plans/advance directives or health care surrogate documents.
- Meet the financial responsibilities associated with your care.
- Follow the care recommended by doctors, nurses and other care team members and remember you are responsible for your actions if you do not follow instructions or refuse treatment.
- If you leave the hospital against the advice of your doctor, the hospital and doctors will not be responsible for any medical consequences that may occur.
- Respect the rights of other patients, families and hospital personnel.
- Keep a quiet restful environment because rest is an important part of healing.
- Not use inappropriate language such as cursing or swearing.
- Respect hospital property.
- Follow hospital rules and regulations that apply to patient conduct.
  Such as:
  - Not smoking on hospital grounds.
- Refrain from behavior that is threatening to staff such as putting another person in fear of bodily injury:
  - Please do not use words, actions, or behaviors that are threatening to oneself or others and that a reasonable person would find threatening, violent, and/or potentially violent.
  - This includes words, actions, or behaviors that reflects a serious 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.

** It is the policy of UF Health to honor all appropriately completed Advance Directives.*

*** Agency for Health Care Administration / 2727 Mahan Drive / Tallahassee, FL 32308 / (888) 419-3456 or Joint Commission on Accreditation of Healthcare Organizations / Office of Quality Monitoring / One Renaissance Boulevard / Oakbrook Terrace, IL 60181 / 800.994.6610*