SHANDS

SHANDS TEACHING HOSPITAL AND CLINICS, INC. CERTIFICATION AND AUTHORIZATION

Shands at U of F • Shands at AGH • Shands at Live Oak • Shands at Starke • Shands at Lake Shore • Shands at Vista • Shands Rehab Hospital • Florida Surgical Center • UF Clinics • Shands Clinics • Shands Homecare

Patient Name _____ Admission Date _____

Account Number _____ Medical Record Number _____

SECTION A: NOTICE OF LIMITED LIABILITY REQUIRED BY SECTION 240.215, FLORIDA STATUTE

I, ON BEHALF OF MY SELF, MY CHILD, AND / OR MY WARD, HEREBY ACKNOWLEDGE I HAVE BEEN INFORMED THAT: Medical care and treatment that I /we receive at a facility owned or managed by Shands Teaching Hospital and Clinics, Inc. may be provided by University of Florida physicians, oral and maxillofacial surgeons, dentists, nurse-midwives, physician assistants, nurse practitioners and students ("health care providers") who are exclusively the employees or agents of the Board of Regents, State of Florida. I understand that those health care providers that are Board of Regents employees and agents are under its exclusive supervision and control; all medical care received from these Board of Regents' health care providers will be under an affiliation agreement whereby Shands provides the Board of Regents a clinical setting for health care education, research and services; and, liability for the acts or omissions of these Board of Regents Health care providers is limited to $100,000 per claim or judgment by any one person and to $200,000 for all claims or judgments arising out of the same incident or occurrence (see Florida Statutes 768.28).

I acknowledge that neither my private physician nor the University of Florida health care providers, are employees or agents of Shands Teaching Hospital and Clinics, Inc. I further acknowledge that I may receive medical care and treatment from other health care providers, including but not limited to radiologists, anesthesiologists, emergency care providers, pathologists, and perfusionists, who are neither employees nor agents of Shands.

Patient/Guardian _____ Date _____ Witness _____

SECTION B: TREATMENT AUTHORIZATION, ASSIGNMENTS OF PROCEEDS, AUTHORIZATION TO RELEASE INFORMATION AND GUARANTOR AGREEMENT

I. Authorization for Routine Diagnostic Procedure and Medical Treatment - I hereby consent to such diagnostic procedures, hospital care, and medical treatment which in the judgment of my physician may be considered necessary or advisable while a patient at a Shands facility. I recognize that Shands is affiliated with a health care teaching and research institution, and that my treatment and care will be observed and in some instances aided by students under appropriate supervision. I consent to the taking of photographs that do not reveal my identity, and the use of all my medical data and any non-identifiable photographs for educational and research purposes at the discretion of my physician. I hereby authorize the University of Florida and/or Shands to retain, preserve and use for scientific, educational or research purposes, or dispose of as they might deem fit, any specimens or tissues taken from my body during hospital or clinic visits.

II. Social Security Medicare (If applicable) - I, the undersigned, certify that the information given by me in applying for Medicare benefits is correct and, if I am an inpatient, that I have received from Shands the Medicare beneficiary notice entitled "An Important Message From Medicare". I authorize Shands and my physicians to release to the Social Security Administration or its representatives any information needed to process this or any other related Medicare claim. I hereby assign payment on my behalf of all authorized benefits to Shands and/or physicians for the unpaid charges for hospital services, and in-hospital physician services furnished by specialists and by physicians for whom the hospital is authorized to bill. I understand that I am personally responsible for payment for any non-covered services, health insurance deductibles and co-insurance.

III. Medicaid (If applicable) - I, the undersigned, certify that I am a recipient of Medicaid benefits. I authorize Shands and my Insurance Carrier to make available to the Medicaid agency in my state any requested information concerning medical, insurance and financial records relating to my hospitalization and/or outpatient care.

IV. Commercial Insurance and Assignment - By signing in the space below as Patient and/or Insured , I hereby assign payment from all insurance carriers with whom I have coverage or from whom benefits are, or may become, payable to me, directly to the hospital and physicians who render services covering this admission/period of treatment, and past and future treatment if related to the incident or condition giving rise to this admission. This assignment shall include settlements or judgments flowing from the incident for which I am receiving treatment and/or master medical benefits otherwise payable to me, but shall not exceed the regular charges for this and any other period of treatment.

V. Release of Medical Information by Shands HealthCare - By signing in the space below as Patient/Guardian, I hereby authorize Shands, and physicians providing services during my hospitalization or outpatient clinic care, to release information from and/or copies of my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests), and other information as may be required for my medical care and to secure payment for charges incurred by me or on my behalf, to: any Shands HealthCare facility or affiliated provider, the Tumor Registry, my physician, to my referring physician, the Guarantor on my accounts, insurance companies for which I have assigned benefits for my treatment and care, or to any sponsors that Shands may later obtain to contribute payment for my treatment and care. I also authorize release of any information to any and all regulatory and/or accrediting organizations as necessary to the hospital/clinic to maintain its licensure and accredited status. I further authorize the Department of Child and Family Services and/or the Social Security Administration to release any confidential case information related to my application for government assistance which is requested by Shands.

VI. Inpatient Valuables Release - By signing in the space below as Patient/Guardian, I acknowledge that I have been given an opportunity to deposit valuables and money for safekeeping. I understand that the hospital assumes no responsibility for personal items or valuables retained by the patient.

VII. Guarantor Agreement - By signing in the space below as Patient/Guardian or Guarantor, or as Patient's/Guardian's Spouse or Guarantor's Spouse, I hereby agree that all charges connected with this treatment, and past and future treatment if related to the incident or condition giving rise to this admission, not covered by any insurance, program, sponsorship or other third party coverage I may have are due and payable by me at the time of discharge or discontinuation of treatment. The charges I agree to pay are those listed in the current Billing Charge Manuals which are available for inspection upon request and incorporated herein by reference. I hereby acknowledge that, unless Shands and my insurance company or third party carrier have agreed that I will not be billed, if Shands Hospital has agreed to bill my insurance or other third party carrier it has agreed to do so as a courtesy and that Shands has the right to demand payment in full from me at any time prior to full payment from any insurance carrier. I hereby acknowledge having been told that I may be billed by both Shands and my treating physicians, including the University of Florida Faculty Group Practice, and that each account for services provided is a separate account and shall be so treated. I further agree that if I am more than thirty (30) days overdue in the payment of any bill connected with this treatment, and past and future treatment if related to the incident or condition giving rise to this admission, a finance charge of 1.5% per month will accrue on the unpaid balance; and if the overdue account is referred by collection, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process.
I specifically waive any exemption of wages from garnishment which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the hospital charges I have agreed to pay.

VIII. Pregnancy - If pregnant, the above authorization, assignments, releases and guarantor agreement apply to my unborn child if born at a Shands facility during this period of treatment.

Patient/Guardian _____ Patient/Guardian's Spouse _____

Insured _____ (If other than patient) Insured _____ (If other than patient)

Guarantor _____ (If other than patient/guardian) Guarantor's Spouse _____ (If other than patient/guardian spouse)

Witness _____ Date _____

COPIES OF THIS STATEMENT SHALL BE AS VALID AS THE ORIGINAL / ORIGINAL SIGNATURES ON FILE IN THE HOSPITAL