MUSC Health

MUSC Health, Ambulatory, and Telehealth Consent for Medical Treatment

Form Origination Date: 7/2003
Version: 15 Version Date: (07/2024)

Patient D.O.B. _____
Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Consent Form for Medical Treatment

I, as the patient or someone responsible for the patient (a parent or legal guardian), consent to and authorize health care providers at MUSC Health sites to give me health care treatment and/or procedures. MUSC Health includes sites owned and operated by Medical University Hospital Authority, University Medical Associates of the Medical University of South Carolina ("MUSC Physicians"), Carolina Family Care, Inc., MUSC Health Partners, and MUSC Community Physicians. I consent to and authorize all tests ordered by MUSC Health providers, including any that check my blood for diseases like infectious diseases such as syphilis, AIDS, and hepatitis, and those that test for drugs.

Consent for Medical Treatment by Telehealth

Telehealth allows you to see and consult your MUSC Health provider by an online visit using your computer, tablet, or smartphone instead of going to their office.

I consent and authorize your MUSC Health provider to provide necessary and/or advisable treatment via Telehealth under the following terms:

- The Telehealth service will be provided in a private and confidential manner,
- However, other individuals may be present to operate the video equipment and they will take reasonable steps to maintain the privacy of the information obtained.
- You have the right to stop the Telehealth visit at any time.
- Telehealth may not be appropriate for your care or if there are technical issues during the Telehealth visit, such as bad audio or video connection, your health care provider or consulting physician may want to see you in person at their office or ask you to visit the hospital for immediate care.

Consent for E-visits via MyChart

An E-visit is an online visit with an MUSC Health provider that can be used instead of a traditional office visit to give you an online diagnosis and treatment plan for certain non-emergency medical conditions.

I consent and authorize for my MUSC Health provider to provide necessary and/or advisable treatment via E-visit. I understand that there may be an additional charge for an E-visit if it is not covered by my insurance company.

MUSC Health is a Teaching and Learning Environment

I understand that MUSC Health is a place where doctors and other health care team members learn and that there might be students watching or helping during my visit. A fully trained doctor will supervise everything. Information

related to the health care I receive may be used for training or for scientific study purposes, but that precautions will be taken to protect my anonymity.

Using Photos, Videos, and Audio Recordings

I agree to let the health care team take pictures or record audio or video if needed for my treatment. These will be kept confidential and secure and will only be used to help with my care.

Agreeing to Phone Calls and Texts

I consent to MUSC Health, its employees, agents, collections agents, service providers and the like, to contact me by telephone at any telephone number that I or my representative provides to MUSC Health. This includes voice calls and/or text messages to the wireless telephone numbers or other numbers. This may result in data usage and other charges to me. These calls may be appointment reminders, information about medical services to be provided, my bills or financial obligations, financial assistance or debt collection for my account(s), or any matter relating to my medical care. MUSC Health will only send general information and nothing confidential. I understand that methods of contact may include pre- recorded or artificial voice messages and/or may be made by automatic telephone dialing systems. I may choose to not receive text messages from MUSC Health by the opt-out message sent with each text.

Responsibility for Personal Belongings

I understand that MUSC Health is not responsible for any valuable things I bring with me, like money, jewelry, electronics, or medication. I understand that it is my responsibility to leave any valuable items at home for safe keeping. Any items left at MUSC Health more than thirty (30) days will be discarded.

<u>Agreement of Financial Responsibility and Assignment of Insurance Benefits</u>

MUSC Health and its providers are authorized to release any medical information required in the processing of applications or submission of information for financial coverage, including information referring to psychiatric care, drug and alcohol abuse, sexual assault, or tests for infectious diseases including AIDS/HIV for services provided during this admission. I / we also agree to the release of medical or other information about to government regulatory agencies (federal or state) as required by law. For Medicare / Medicaid beneficiaries – I / we have provided all necessary information for proper assignment of Medicare / Medicaid benefits.

In return for the services rendered and to be rendered by MUSC Health, I hereby guarantee the payment of all charges associated with services received from MUSC Health. I hereby irrevocably assign and transfer to MUSC Health all right, title, and interest in all benefits payable for the healthcare rendered, which are provided in any and all insurance policies and health benefit plans from which I am entitled to recover, including but not limited to hospitalization, medical, third party liability insurance coverage, workers compensation benefits, employer, employer group, individual, welfare benefit, trust sponsored, and benefits paid by Medicare or Medicaid. This

assignment is intended to include any interest in benefits that I may have relating to this date of service as well as any prior dates of service.

By executing this assignment of benefits, I am requesting that all insurance companies pay MUSC Health directly for the services MUSC Health provided to the patient. I understand that any payment received from these policies and/or plans will be applied to any outstanding balance that I may have with MUSC Health. I further understand that I am not entitled to a refund unless all MUSC Health bills are paid in full for any outstanding balances owed to them. If a third party may be obligated to pay some or all of these charges, I agree to take all actions necessary to assist MUSC Health in collecting payment from any such third-party payer. I hereby appoint MUSC Health as my authorized representative to pursue, if it so chooses, all administrative remedies, claims, appeals, and/or lawsuits on my behalf and at MUSC Health's election, against any responsible third party, medical insurer, or employer sponsored medical benefit plan for purposes of collecting any and all hospital benefits due me for the payment of the charges. I authorize MUSC Health to endorse and retain benefit checks made payable directly to me.

I understand that MUSC Health may bill an insurance company, as a courtesy to me, but may not be obligated to do so. I understand if MUSC Health initially accept health insurance coverage, this does not waive their rights to collect or accept, as payment in full, any payment made under a different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment. I understand that Professional Services may be rendered by independent contractors and are not part of MUSC Health bills. I understand that care that is experimental as determined by my insurance company may not be covered and that I will be responsible for those charges. I agree that if my account is not paid, it may be turned over to a collection agency or attorney, and I must pay the amount due plus all costs of collection, including reasonable attorney’s fees and costs.

I understand that if I am unable to pay my bills, I may speak with a Financial Counselor to determine whether I qualify for assistance. The telephone number for the Financial Counselor of MUSC Health is (843) 792-2311.

I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by MUSC Health.

What this means:

- I agree for MUSC Health to release my personal health information to my insurance, or any government agencies as required by law.
- I agree that I am responsible for all charges and request all insurance companies pay MUSC Health directly.
- Any payments from my insurance company may be applied to any outstanding balance.
- I understand I may not be entitled to a refund unless any past due MUSC Health bills are paid in full.
- MUSC Health may bill an insurance company as a courtesy to me but is not obligated to do so.
- I understand my insurance company determines what they pay for, and it is not the responsibility of MUSC Health to make this determination.
- I agree that if my account is not paid, it may be turned over to a collection agency or attorney, and I must pay the amount due plus all costs of collection.

Medicare Patient Certification (Medicare patients only)

I hereby certify that I have provided information about all insurance coverage available to me, including liability or worker's compensation insurance, and that the information provided is correct and complete. I hereby authorize MUSC Health to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or a related Medicare claim. I hereby authorize the payment of benefits to MUSC Health.

Agreement of Financial Responsibility for Non-Covered Services (Not applicable for all patients)

By signing and dating this form, I am indicating that I have been informed by MUSC Health or other related organization that the services the patient will receive today may not be covered because of the reasons including but not limited to those listed below:

- MUSC Health / the rendering physician is not a contracted / credentialed provider for your health plan. You will be responsible for any amounts not covered by your insurance plan.
- Your insurance carrier / primary care physician has not provided a referral / authorization for today's service. You will be responsible for any amounts not covered by your insurance plan.
- Your condition may be considered pre-existing based on the length of your coverage under your insurance plan.
- Your service may not be considered medically necessary by your insurance plan. You may be responsible for the entire cost of the service.
- Other reasons not listed here

Release of Information Specific to Alcohol and Substance Abuse Treatment Programs

There are strict federal confidentiality laws for the release of information about patients involved in alcohol and drug abuse treatment programs at MUSC Health. These federal regulations (42 CFR Part 2) prohibit MUSC Health from releasing any information about the patient's participation in an alcohol or drug abuse treatment program without written permission from the patient. There are exceptions for information about a crime or a threat of a crime or suspected abuse or neglect, which can be reported to state or local authorities. Information about the patient can be released without patient consent in the following situations: 1) internal program communications; 2) to medical personnel in medical emergencies; and 3) when there is a valid court order for the information. Disclosure of information that does not contain patient identification information can be made for research or audit purposes without patient consent. Otherwise, MUSC Health cannot release information to anyone unless a separate consent form is filled out and signed by the patient to authorize MUSC Health to release specific information to specific people or organizations.

HIPAA (Health Insurance Portability and Accountability Act) Disclosure/Use of Health Information Notification

The MUSC Organized Health Care Arrangement's (OHCA) Notice of Privacy Practices can be found here (https://web.musc.edu/about/compliance/privacy).

I certify that I have reviewed and/or received a copy of the MUSC OHCA "Notice of Privacy Practices" which describes how MUSC Health uses and disclosures my personal health information.

Patient D.O.B. _____
Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

I understand that this consent for medical treatment, assignment of insurance benefits and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice.

I certify that I have read, or someone has read to me this consent and I agree to its terms.

I also certify that I am the patient, or am duly authorized by the patient, or am duly appointed to sign this agreement.

_____ _____ _____ AM/PM
Signature of Patient/Legal Representative Date Time

_____ _____
Print Name of Patient/Legal Representative Relationship to Patient

_____ _____ _____AM/PM
Witness Signature Date Time