

PATIENT CONSENT AND ACKNOWLEDGMENT

This is a Lifespan standard Patient Consent and Acknowledgement used when registering patients at any Lifespan Affiliated Hospital (Bradley, Newport, Rhode Island, The Miriam), their hospital Clinics, Gateway Healthcare, Lifespan Physician Group, Inc. and Telemedicine Visits (“Care Sites”)

CONSENT TO EXAMINATION AND TREATMENT - I understand that I may require examinations, medical and diagnostic procedures, medications, and in some instances, additional therapies, in connection with the diagnosing and treatment of my medical condition. I hereby consent to the performance of such examinations and procedures as may be deemed appropriate by the clinicians providing care to me (the “Care Team”). I understand that tissue and biologic fluids such as blood or urine may be collected in that examination and diagnosing process, and that they may also use such specimens for diagnostic, education, quality improvement, scientific or certain research purposes. I further understand that photographs, videotapes, audiotapes, digital or other recordings may be taken for identification purposes, unless I decline, or to document my medical condition or care and/or for internal education and quality assurance purposes.

I understand that the provision of health care is not an exact science, and I acknowledge that no guarantees have been made to me about the effectiveness of any procedures, treatments, examinations, or other healthcare services. I further understand that my Care Team will inform me about what is the most reasonable course of action for my condition, and that such a course of action will be identified and taken with my best interest as a patient in mind. I understand that I have the right to withhold consent to any medical or surgical procedure or healthcare service. I understand that the Care Site has the right to decline to perform any procedure if I, or my representative(s), have not clearly provided an informed consent. I realize that if I, or my designated representative(s), withhold consent for a recommended procedure, that treatment may be rendered partially or wholly ineffective.

CONSENT TO EXAMINATION AND TREATMENT OF NEWBORN - If I should deliver a baby during this encounter, I consent to having any needed treatment provided to my newborn(s).

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION TO PROVIDER – I understand that providers on staff at a certain Care Site may not be employees of that particular Lifespan Care Site. I hereby authorize payment of my health insurance benefits directly to the applicable Lifespan entity and to any Lifespan affiliated provider rendering services during this hospitalization or visit. I understand that I am responsible for charges not covered by my insurance company and I understand it is my responsibility to meet the contract requirements of my health plan. I understand I may receive separate bills from services providing emergency care, interpretation of x-rays and other diagnostic imaging, and that some providers’ services may be billed separately from the Care Site services.

MEDICARE AUTHORIZATION - To the extent I am covered by Medicare, I agree to the conditions of admission for hospitalization outlined in this agreement. I certify that all the information I provided in connection with my application under the Medicare Program (Title XVIII of the Social Security Act) is correct. I request that payment for any authorized Medicare benefits to be made on my behalf be made to the hospital or its employed providers. I authorize any holder of medical information or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine my entitlement to these Medicare benefits or benefits for related services.

FINANCIAL RESPONSIBILITY - I agree, in order for Lifespan to service my account or collect any amounts I may owe, Lifespan may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable.

I authorize the Care Site to apply any outstanding credit balance I may have on my account to satisfy to the fullest extent possible any outstanding account balance(s) I may have with a different Care Site before processing any patient refund to me.

ELECTRONIC COMMUNICATIONS – I agree to the receipt of electronic communications of an administrative nature from Lifespan. Methods of transmission might include emails, text messages, phone messages, and other electronic means that

might become available. The purpose of these communications might include but shall not be limited to appointment scheduling or reminders, notifications concerning the MyLifespan patient portal, program registrations, surveys, general inquiries, or billing/payment issues. By agreeing to these transmissions, I acknowledge that the privacy and security of electronic communications cannot be guaranteed and that parties with whom I have chosen to share electronic addresses or phone numbers may be aware of such transmissions and may have the means to access my personal health information using information from these transmissions.

RIGHT TO ADVANCE DIRECTIVES – If my level of care is deemed to be inpatient and/or observation, I have been given written information on my right to make medical decisions and to have advance directives (in the form of a living will or Durable Power of

Attorney for Health Care). I understand that it is my responsibility to provide my Care Team with a copy of my advance directive, and that failure to do so may mean my wishes are not known to my providers. I understand that my advance directive will be handled with appropriate sensitivity and confidentiality and that I will be provided with the same quality of care whether or not I have an advance directive.

PERSONAL BELONGINGS - I understand that Lifespan cannot be responsible for my personal belongings and I am assuming the risk of loss if I have brought them with me to the Lifespan hospital/affiliate.

PERSONAL ELECTRONIC DEVICES - I understand that the use of personal electronic devices by patients and/or visitors for the purposes of taking and/or transmitting photographs, video recordings, or audio recordings, of patients, medical staff, or hospital employees, is prohibited.

NOTIFICATION SECURITY CAMERA USE - I understand that security cameras are in place in certain public areas of the hospital including some patient areas.

LIFESPAN PHARMACY CONCIERGE MEDS TO BEDS SERVICE – If I am registering to be, or as a result of my care am made, an Inpatient of Rhode Island Hospital, The Miriam Hospital or Newport Hospital. I am also being asked to extend my acknowledgement and consent to enroll in their concierge Meds-2-Beds program:

I understand that I will be automatically enrolled in Lifespan’s concierge Meds-2-Beds program to help navigate prescription issues with my insurance company and ensure that I have my discharge medications in hand upon leaving. This will involve Lifespan’s retail pharmacy staff performing any necessary benefits investigations, securing necessary prior authorizations, filling my discharge medications, and delivering to my room prior to discharge. At any point through and including to the point of delivery, if I wish to decline this service, then I can advise my care team or a representative of Lifespan Pharmacy, and Lifespan Pharmacy will gladly reverse any and all claims and facilitate transferring my prescriptions to a pharmacy of my choosing when notified.

CONSENT TO A LIFESPAN (42 CFR PART 2) PROGRAM TO DISCLOSE MY DRUG/ALCOHOL TREATMENT INFORMATION - If I am

registering for, or as a result of my care, receive drug or alcohol (substance use disorder-related) treatment at any provider entity affiliated with Lifespan, I also extend my acknowledgement and consent to the following:

I consent to allow that Lifespan program to disclose all my substance use disorder-related claims and encounter data including but not limited to my history, diagnosis, medication, treatment and other such identifying information to my LifeChart record (my electronic health record at Lifespan) and to my treating providers and professionals who are authorized to access my LifeChart record, whether or not they practice at a Lifespan affiliate. This consent will expire if and when Lifespan, or its successor organization, and LifeChart or its successor electronic medical records system, no longer exist. I further consent to allow Lifespan to make a referral for certified peer recovery specialist services.

I understand that I may revoke this consent in writing with notice to the Lifespan program(s) where I have obtained drug or alcohol treatment at any time. I also understand, however, that I cannot withdraw my consent for disclosures that have already been made in reliance on my original consent.

I also understand my right to request a list of entities to which my drug or alcohol treatment information has been released by my Lifespan treating program(s) pursuant to this consent. I understand that I am only entitled to this list of entities to which disclosures have been made in the two years prior to my request.

By signing this consent form below, I acknowledge that I understand this consent form, and that it means my treatment information which is protected under the federal confidentiality regulations at 42 CFR Part 2 can be released to my LifeChart record and accessed by my treating providers and professionals.

If the visit is to be conducted via telemedicine, we need to inform you and you need to understand that:

- You are consenting to the discussion of your confidential and protected health information (PHI) and to treatment by interactive audio, video, or data communications, so called "telemedicine," which includes the exchange of information, both orally and visually, as if we were having a discussion at the hospital or other treatment site.
- You have the right to withhold or withdraw consent at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you may otherwise be entitled.
- The information disclosed by you during your treatment is generally confidential under law, unless such disclosures are mandated or permitted under law such as for, among other reasons, reporting child, elder, and dependent adult abuse; or if there are expressed threats of violence towards an ascertainable victim.
- If you participate in telemedicine, you agree to do so from a private area.
- There are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts, that: the transmission of your medical information could be disrupted or distorted by technical failures, or interrupted or intercepted by unauthorized persons during transmission and/or electronic storage of your medical information.
- Telemedicine based services and care may not be as complete as face-to-face services, and you may be better served by another form of treatment services (e.g. face-to-face services) which can be discussed if indicated.
- You understand that there are potential risks and benefits associated with any form of treatment, and that despite our best efforts, your condition may not improve, and in some cases may even get worse.
- Your health insurance plan will be billed for telemedicine services. If required, you will be responsible for any co-payments or deductibles.

ACKNOWLEDGMENT - I certify that I have read the above and that it has been explained to me so that I understand it. I certify that I am the patient, the patient's parent/guardian, or a duly authorized patient representative, able to review the above terms and accept them. I understand that this visit may be conducted in-person or via telemedicine.

PATIENT (or PATIENT'S GUARDIAN / AGENT / REPRESENTATIVE)

Signature: _____

Patient Relationship: _____

Print Name: _____

Date: _____ Time: _____