Columbia Surgical Associates
An Affiliate of Health Care

Health Care
University of Missouri Health System

UMHC ANNUAL ENROLLMENT AGREEMENT

This is your agreement with University of Missouri Healthcare (UMHC) (including Columbia Surgical Associates) about the UMHC annual enrollment process. This agreement confirms your consent to healthcare and your agreement to be financially responsible for all charges related to your visit services as provided below. The agreement allows UMHC healthcare providers to access your health information. UMHC may cancel this agreement in appropriate circumstances.

Since the use of the annual enrollment allows UMHC providers access to your medical record, please read this agreement carefully. You will be asked to sign and to accept these terms and conditions. If you are signing on behalf of someone else, you agree that you are authorized to sign this agreement for that person.

Consent for Treatment/Conditions of Service

By presenting and enrolling in this program you agree that you wish to receive services at UMHC for either inpatient or outpatient services and agree to all terms and provisions of this UMHC annual enrollment Agreement. You understand and agree to the following:

Consent for My Health Care

I give my consent to health care which may include tests, drugs, exams, and other care asked for in order to treat me. I give my consent for hospital treatments ordered which may include routine health tests, stabilization, and medical treatments such as

* X-Rays
* Local anesthesia
* Lab tests
* Procedures
* IVs (intravenous) and other modes of giving me medicine and nutrients

For Invasive procedures requiring anesthesia or conscious sedation, separate consent forms will be need to be completed.

I know that the UMHCs (University of Missouri Healthcare) Mission includes research, teaching and patient care. Plus, I know that my health care, while overseen by an attending doctor, may be given by a member of the health care team like a nurse and other health expert(s). I know that I may be asked about research which pertains to my health care. I know that I have the right to give my consent to be a part of these research studies. Or, I have the right to deny consent. I have a list and know my Patient Rights and Responsibilities as a patient of UMHC. I know that UMHC is not liable for my health and safety if I choose to leave the hospital building during my care. I understand that my nurse will ask me questions about my discharge plans, however, if I would like more assistance with discharge planning I may request a full discharge evaluation from social services.

Telehealth services

I know that I can now get some of my health care by interactive video or the electronic transfer of information. This technology may help to assess, diagnose and treat lots of health care problems. This type of care is called “telemedicine” or “telehealth.” This means that I may get some health care from someone who is not in the same room as me. I agree and will allow such care.

I know that all telehealth care will be tracked in my health records. These records may have notes, pictures and other health information gained from my health care session. I will let UMHC, as well as anyone else who gives me health care, send the health information gained through telehealth to my own doctor and insurer (if I have one). Plus, if someone gives me health care, they may send my health records to anyone else who may, by law, view and use them.

I know that the options below are available to me when I get care through telehealth:

1. Someone will be in the room with me to help with the visit. I have the right to be told about all parties who will be a part of my care, both at my site and the remote site. I can choose to exclude a person at either site. I know that there are some people that must be involved at both sites. If I choose to exclude a person at either site, I know that someone else may need to take part for the telehealth services to be given.
2. I can choose to get my health care in the "usual" way (for example, an in-person visit). I can ask about other types of care from my health care providers. If I choose not to use telehealth for my care, I know that it may be up to me to set up a different kind of care.
3. I can get telehealth information in the same way that I get other information in my health records. This is consistent with all laws and UMHC rules that apply.
4. Each telehealth session involves sending things from the meetings with my doctor. Each visit may need to be watched and a record made. This may be done through the use of still pictures or sounds with diagnostic worth. UMHC does not store videos of telehealth sessions. If a telehealth session is videoed or recorded, I have the right to choose to object.
5. I may refuse telehealth services at any time. If I do, it will not affect my right to future care or treatment. Also, if I use MO HealthNet, I will not be at risk of losing my MO HealthNet benefits.

Privacy and Identity Theft Safety

I know that some things may be newsworthy. I agree that basic reports of my condition (these are "critical, serious, fair, and good") may be sent to the news media in UMHCs best judgment unless I have requested confidential treatment of that information at time of admission. If I do not want such reports to be sent, I will inform appropriate staff.

I understand that UMHC is committed to protecting me and my privacy and agree to follow UMHC privacy policies. For my safety as a patient, a photo may be requested to be taken of me. I will let UMHC take pictures or video of me for use in my care, to educate and for quality. Photographs, video and images taken for patient care and treatment will be included as a part of my health record. I know that UMHC utilizes security cameras in the hospital to keep all patients safe.

My Personal Items

UMHC will not be at fault if any of my own property is lost, damaged or stolen. The same is true for all the things my visitors might bring with them. The hospital has a safe that I can put valuables in.

<u>Financial Agreement/Assignment of Insurance and Agreement to Pay</u>

Paying for My Care:

I, my insurance carrier(s), or both will pay for my health care as soon as possible. My insurer and other payment sources are authorized to pay UMHC (University of Missouri Healthcare) directly for all of the health care I get. I assign to UMHC the right to receive payment for health care provided by UMHC from the following sources:

Primary (first to pay) and secondary (next to pay) benefits such as:

Medical insurance
Health insurance (HMO, PPO, other)
Hospital insurance
Accident insurance, including auto medpay
Medicare
MO Healthnet (Medicaid, Missouri Care, etc)
CHAMPUS, VA, Tricare
Claims from workers compensation or work-related disease
My own money, estate, or other funds to which I am entitled

Insurance Coverage:

I agree to let UMHC know if I have current insurance or other payment sources available to pay for my health care costs. If I have not told UMHC of such coverage, I understand that I will be responsible for, and agree to pay for the costs of my care.

If I can't pay for my care, I will tell UMHC at once to see if I can get help from UMHC.

Non-Covered Costs:

I agree to pay all UMHC costs that are not paid by my insurer or third party payer. These costs might be things such as deductibles and co-insurance. This may also include costs not paid due to me not getting authorized or a referral before treatment as I should have.

If the bill(s) is sent to collection, I will pay UMHCs lawyer fees and collection costs. Plus, UMHC may add a credit balance to all other accounts of mine.

Other Services:

I understand that I will receive separate bills for care provided by my health care providers and care provided by the hospital. Separate bills are issued for things like anesthesiologist and pathologist fees.

Help for Patients Who Do Not Have Health Insurance or May be Underinsured:

If I am uninsured and cannot pay for the care received, I will tell UMHC at once to see if I can get help from UMHC or other group(s) to pay for my health care.

Consent for Release of Health Records:

UMHC and the health care providers who care for me may give all or parts of my health records to a referring doctor, if there is one, when asked.

I will let any insurance company that will pay my health care bill(s) have access to my records. UMHC may send parts of my health record(s) to all health care providers or doctors to which my care may be moved. If I do not want my records sent to another health care provider or payment source, it will be my responsibility to inform the clinic or hospital.

I want the hospital to bill my insurance or other payment source for care that is provided to me. If I have a visit that I do not want billed, it will be my responsibility to inform the clinic or hospital.

***Special Information for Medicare Recipients*:**

I understand that some of the UMHC facilities are hospital-based providers and that I will be responsible for both hospital and physician coinsurance amounts for the care that I receive. At this time, the exact nature and extent of the care that I will receive are not known. The actual amount that I owe will depend on the actual services that I receive. In facilities that are hospital-based, I understand that I may incur coinsurance liability to the hospital that I would not incur if the facility were not hospital-based.

I will need to respond to the Medicare secondary payer screening at each visit.

YOU AGREE NOT TO USE THE UMHC ANNUAL ENROLLMENT UNTIL YOU HAVE FULLY READ AND UNDERSTAND ALL OF THE TERMS OF THE ABOVE AGREEMENT.

Acknowledgement and Agreement

I have been provided with a UMHC annual enrollment Agreement, a copy of my patient rights, and a copy of the
University Of Missouri Healthcare Notice Of Privacy Practices.

I agree to the terms and conditions set forth in the annual enrollment Agreement. That Agreement will remain in full force and effect for 12 months. I understand that at each visit I will be asked to confirm limited information. If any of the information that I have provided changes during the 12 month period, I will inform UMHC of those changes at my next visit.

Print Patient Name | Patient/Representative signature | Date