Consumer Access Welcome Packet

Thank you for choosing AdventHealth for your healthcare needs. This packet will include copies of the forms pertaining to your registration. Please use these forms as reference during the signature process.

Included in this packet:

Notice of Patient Privacy Practices

Patient Bill of Rights

Form No Surprises Act Model Disclosure Notice

Admission and Treatment Consent

Advanced Directives

Health Equity Promise

Understanding Your Emergency Room Cost

Joint Notice of Privacy Practices

Effective Date: April 1, 2024

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

If you have any questions about this notice, please contact our Privacy Officer at 800-906-1794/TTY: 407-200-1388.

Section A: Who Will Follow This Notice

This notice describes AdventHealth's practices and that of:

- Any health care professional authorized to enter information into your medical record maintained by an AdventHealth facility, such as doctors, nurses, physician assistants, technologists and others.
- All departments and units of AdventHealth facilities, including hospitals, outpatient facilities, physician practices, skilled nursing facilities, home health agencies, hospices, urgent care centers, and emergency departments.
- All employees, staff, students, volunteers and other personnel of AdventHealth facilities.
- All third-party business partners that assist AdventHealth with providing technology tools or other healthcare operations.

If you would like a list of AdventHealth affiliated entities, please send a written request to the Privacy Officer at the address below in Section G.

Section B: Our Pledge Regarding Your Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our facilities. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or maintained by AdventHealth facilities, whether made by our employees or your personal doctor. If your personal doctor is not employed by AdventHealth, your personal doctor may have different policies or notices regarding your doctor's use and disclosure

of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Use our best efforts to keep medical information that identifies you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

We may share your medical information in any format we determine is appropriate to efficiently coordinate the treatment, payment, and health care operation aspects of your care. For example, we may share your information orally, via fax, on paper, or through electronic exchange.

We also ask you for consent to share your medical information in the admission documents you sign before receiving services from us. This consent is required by state law for some disclosures and allows us to be certain that we can share your medical information for the reasons described below. You may view a list of the main state laws that require consent (Attachment A) by clicking here https://www.adventhealth.com/legal/patient-privacy-hipaa, or you may ask the registration clerk for a paper copy. If you do not want to consent to these disclosures, please contact the Privacy Officer to determine if we can accept your request.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other AdventHealth personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of AdventHealth also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside AdventHealth who may be involved in your medical care for referrals, or your family members, friends, clergy or others we use to provide services that are part of your care.

- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at AdventHealth may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at AdventHealth, so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.

- **Health Care Operations.** We may use and disclose medical information about you for AdventHealth's operations. These uses and disclosures are necessary to run AdventHealth and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may use and disclose your information as needed to conduct or arrange for legal services, auditing, or other functions. We may allow your medical information to be accessed, used or disclosed by our business associates that help us with our administrative and other functions. These business associates may include consultants, lawyers, accountants, software licensors and other third parties that provide services to us. For example, we license software with certain artificial intelligence enabled technology that processes data about you that is then reviewed by your physician or care provider to help treat you (e.g., the software within fetal heart monitors, and EKG and MRI machines) or to help your physician or care provider be more efficient (e.g., dictation software). The business associates may re-disclose your medical information only as necessary for our treatment, payment, health care operations and related functions, or for their own permitted administrative functions, such as carrying out their legal responsibilities. We may also combine medical information about many patients to decide what additional services AdventHealth should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other AdventHealth personnel for review and learning purposes. We may also combine the medical information we have with medical information from other entities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. Once we have removed information that identifies you, we may use the data for other purposes. We may also disclose your information for certain health care operation purposes to other entities that are required to comply with HIPAA if the entity has had a relationship with you. For example, another health care provider that treated you or a health plan that provided insurance coverage to you may want your medical information to review the quality of the services you received from them.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or

medical care at AdventHealth.

- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities.** We may use information about you to contact you in an effort to raise money for AdventHealth and its operations. We may disclose information to a foundation related to AdventHealth so that the foundation may contact you to raise money for AdventHealth. We would release only contact information, such as your name, address, phone number, gender, age, health insurance status, the dates you received treatment or services at AdventHealth, the department you were treated in, the doctor you saw, and your outcome information. If you do not want AdventHealth to contact you for fundraising efforts, you must notify us in writing as set forth in Section G.

- **Patient Directory.** Unless you tell us otherwise, we may include certain limited information about you in AdventHealth's patient directory while you are a patient at AdventHealth. This information may include your name, location in AdventHealth, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Unless you tell us otherwise, your religious affiliation may be given to a member of the clergy, such as a minister, priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in AdventHealth and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you tell us otherwise, we may release medical information about you to a friend or family member who is involved in your medical care; we may give information to someone who helps pay for your care; or we may tell your family or friends your condition and that you are in an AdventHealth facility. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes including to our research affiliates. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects involving people, however, are subject to a special approval process by an Institutional Review Board. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, unless most or all of the patient identifiers

are removed, the project will have been approved through this research approval process. We may, however, provide limited read-only access to medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review remains protected. If required by law, we will ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at AdventHealth.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal, state or local law. For example, when our patients have certain transmissible diseases, suffer from abuse, neglect or assault, or for state registries such as the Office of Vital Statistics or tumor registries. Another example would be for work related injuries or illnesses, or workplace related medical surveillance.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Section D: Special Situations

- **Organ and Tissue Donation.** We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may also disclose information to entities that determine eligibility for certain veterans' benefits.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

  - To prevent or control disease, injury or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

➢ **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

➢ **Lawsuits and Disputes.** We may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

➢ **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at AdventHealth; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

➢ **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of AdventHealth to funeral directors as necessary to carry out their duties.

➢ **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

➢ **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

➢ **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your

health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy some of the medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. When your medical information is contained in an electronic health record, as that term is defined in federal laws and rules, you have the right to obtain a copy of such information in an electronic format and you may request that we transmit such copy directly to an entity or person designated by you, provided that any such request is in writing and clearly identifies the person we are to send your PHI to. If you request a copy of the information, we may charge a fee for the costs of labor, copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy medical information in certain circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting

  the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the healthcare entity. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the healthcare entity;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. The accounting will exclude certain disclosures as provided in applicable laws and rules such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members

involved in your care, disclosures for notification purposes and certain other types of disclosures made to correctional institutions or law enforcement agencies. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

  We are not required to agree to your request, except in limited circumstances where you have paid for medical services out-of-pocket in full at the time of the service and have requested that we not disclose your medical information to a health plan**.** To the extent we are able, we will restrict disclosures to your health plan. We will not be able to restrict disclosures of your medical information to a health plan if the information does not relate solely to the health care item or service for which you have paid in full. For example, if you are having a hysterectomy that will be paid for by your health plan, and you request to pay cash for a tummy tuck that you want performed during the same surgery, to avoid disclosure to your health plan, you would either have to pay cash for the entire procedure or schedule the procedures on separate days. Please also know that you have to request and pay for a restriction for all follow-up care and referrals related to that initial health care service that was restricted in order to ensure that none of your medical information is disclosed to your health plan. You, your family member, or other person may pay by cash or credit, or you may use money in your flexible spending account or health savings account. Please understand that your medical information will have to be disclosed to your flexible spending account or health savings account to obtain such payment.

  If we do agree, we will comply with your request unless the disclosure is otherwise required or permitted by law. For example, we may disclose your restricted information if needed to provide you with emergency treatment.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to

be contacted.

- **Right to a Notice of Breach.** You have the right to receive written notification of a breach if your unsecured medical information has been accessed, used, acquired or disclosed to an unauthorized person as a result of such breach, and if the breach compromises the security or privacy of your medical information. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first-class mail or, if necessary, by such other substituted forms of communication allowable under the law.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, https://www.adventhealth.com/legal/patient-privacy-hipaa.

- **Right to Decline Participation in Health Information Exchange.**

  AdventHealth has electronically connected patient medical information to the AdventHealth health information exchange application known as Epic's Care Everywhere and other related applications and services ("HIE applications"). HIE applications provide interoperability functions that connect us with other health information exchange organizations to share patient medical information to and from other health care providers, Health Information Service Providers (HISP), health plans, and government agencies. Making patient medical information available through the AdventHealth HIE applications promotes efficiency and quality of care.

  You may choose not to allow your medical information to be shared through the AdventHealth HIE applications. Sharing medical information through the AdventHealth HIE applications is not a condition of receiving care. To opt-out of the AdventHealth HIE applications, send a written request to the Privacy Officer at the address or email address provided in section G below or request to sign an HIE application cancellation form when you visit an AdventHealth facility. Please note that any medical information about you previously made available through HIE applications to other recipients is not controlled by AdventHealth. To opt-out of certain other national, regional or state health information exchanges, you must contact the specific HIE applications or your other providers or insurance companies and follow their opt-out process.

  Once AdventHealth processes your HIE application opt-out request, healthcare providers outside of AdventHealth can no longer view your medical information originating from AdventHealth. This means it may take longer for healthcare providers external to AdventHealth to get medical information they may need to treat you. Your opt-out request will remain in effect until you provide a written request to AdventHealth to start sharing your medical information through the AdventHealth HIE again. Even if you do not participate in a health information exchange, certain state law reporting requirements, such as the immunization

registry, will still be fulfilled through health information exchange. Some states also allow healthcare providers to access your medical information through a national, regional, or state health information exchange if needed to treat you in an emergency.

To exercise the above rights, please contact the following individual to obtain a copy of the relevant form you will need to complete to make your request: The Privacy Officer at 800-906-1794/TTY: 407-200-1388.

Section F: Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in AdventHealth, as well as on our website. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to an AdventHealth facility for treatment or health care services, we will make available a copy of the current notice in effect.

Section G: Do You Have Complaints or Concerns?

If you believe your privacy rights have been violated, you may file a complaint with AdventHealth or with the Secretary of the Department of Health and Human Services. To file a complaint with AdventHealth, please contact: The Privacy Officer at 800-906-1794/ TTY: 407-200-1388, or email at patientrequest@adventhealth.com, or send mail to AdventHealth, 900 Hope Way, Altamonte Springs, FL 32714, Attn: Privacy Officer. All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

Section H: Other Uses of Medical Information That Require Your Authorization

The following types of uses and disclosures of medical information will be made only with your written permission.

- **Psychotherapy Notes**. Psychotherapy notes are notes that your psychiatrist or psychologist maintains separate and apart from your medical record. These notes require your written authorization for disclosure unless the disclosure is required or permitted by law, the disclosure is to defend the psychiatrist or psychologist in a lawsuit brought by you, or the disclosure is used to treat you or to train students.

- **Marketing**. We must get your permission to use your medical information for marketing unless we are having a face-to-face talk about the new health care product or service, or unless we are giving you a gift that does not cost much to tell you about the new health care product or service. We must also tell you

if we are getting paid by someone else to tell you about a new health care item or service.

- **Selling Medical Information**. We are not allowed to sell your medical information without your permission and we must tell you if we are getting paid. However, certain activities are not viewed as selling your medical information and do not require your consent. For example, we can sell our business, we can pay our contractors and subcontractors who work for us, we can participate in research studies, we can get paid for treating you, we can provide you with copies or an accounting of disclosures of your medical information, or we can use or disclosure your medical information without your permission if we are required or permitted by law, such as for public health purposes.

If you provide us with authorization to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Section I: Organized Health Care Arrangement

AdventHealth, its Medical Staff, and other health care providers affiliated with AdventHealth have agreed, as permitted by law, to share your medical information among themselves for purposes of your treatment, payment or health care operations at AdventHealth. We may participate in organized health care arrangements with other covered entities, like other health care providers, that are not our agents for purposes of joint utilization review, quality assessment and improvement activities, or payment activities. Each are independent entities responsible for their own activities. This enables us to better address your health care needs.

In an effort to control health care costs, while still providing quality care, AdventHealth, independent contractor members of its Medical Staff and other health care providers in the communities where AdventHealth provides services have also joined together or may be in the process of joining together to create networks of providers or accountable care organizations to provide and manage your treatment, as well as to conduct population health research to improve the quality of care in our communities. We ask you to consent to the release of your medical information and super sensitive data in our admission documents when you come to our facility. If you would like to restrict these disclosures, please contact the Privacy Officer as set forth in Section G to determine if we can accept your request. Please also contact our Privacy Officer if you would like to see a list of the networks, organized health care arrangements, affiliated covered entities, or accountable care organizations AdventHealth participates in.

HEALTH CARE FACILITY
PATIENT RIGHTS AND RESPONSIBILITIES
(COLORADO, GEORGIA, ILLINOIS, KANSAS, KENTUCKY, NORTH CAROLINA, TEXAS, WISCONSIN)

Federal and state law provide you certain rights and responsibilities while you are receiving healthcare services. We are committed to making every effort to protect and uphold your rights. If you have any questions or would like additional information, including a copy of the full text of your state's laws regarding your rights and responsibilities, please ask. Your rights and responsibilities include:

Quality of Care and Decision Making

You have a right to:

- An interpreter when you do not speak English and an interpreter is available;
- Be informed of the facility's policies regarding your rights during the admission process;
- Not to be discriminated against on the basis of race, color, national origin, disability, or age;
- Care and treatment, in compliance with state statute and consistent with sound and quality nursing and medical practices, that is competent and respectful, recognizes a person's dignity, cultural values and religious beliefs, and provides for personal privacy to the extent possible during the course of treatment;
- A reasonable response to your requests and needs for treatment or service, within the hospital's capacity, its stated mission, and applicable law and regulation and to have your care, treatment, and service needs met and receive care in a safe setting;
- Be informed of your health status, including full information in laymen's terms, concerning your condition and diagnosis, proposed treatment and prognosis, including information about alternative treatments and possible complications;
- Participate in all decisions regarding the development and implementation of your plan of care;
- Make informed decisions regarding your care;
- Know names, professional status, and experience of the staff providing care or treatment to the patient;
- Be informed of the name, business telephone number and business address of the person supervising your services and how to contact that person;
- Choose the participating physician responsible for coordinating your care;
- Request or refuse treatment, drug, test, or procedure, and be informed of the risks and benefits of your request or refusal;
- Except for emergencies, to give informed consent prior to the start of any procedure or treatment, or both, and to have care implemented without unnecessary delay;
- Be promptly and fully informed of any changes in your plan of service;
- Be free of all forms of neglect, abuse (physical or mental), corporal punishment, or harassments;
- Be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff; and
- Formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives;
- Appoint a surrogate to make health care decisions on your behalf to the extent permitted by law;
- Have a family member or representative of your choice and your own physician notified promptly of your admission to the hospital;
- Know whether referrals to other providers are entities in which we have a financial interest;
- Know whether the health care entity is participating in teaching programs;
- Receive an explanation of the nature and possible consequences of any research or experimental procedure before the research or experiment is conducted and provide prior informed consent and to refuse to participate;
- Be advised when a physician is considering you as a part of a medical care research program or donor program, to give informed consent prior to actual participation in such a program, and to, at any time, refuse to continue in any such program;

- Provide informed consent prior to being included in any clinical trials relating to your care;
- Have your property treated with respect;
- Assistance in obtaining consultation with another physician or practitioner at your request and expense;
- Not be denied the right of access to an individual or agency who is authorized to act on your behalf to assert or protect your rights;
- If you are an Illinois patient:
    - visitation by any person or persons designated by you who is eighteen (18) years of age or older and who is allowed rights of visitation unless: (i) the facility does not allow any visitation for a patient, or (ii) the facility or your physician determines that visitation would endanger your or your visitor's physical health or safety or would interfere with the operations of the facility; and
    - timely, prior notice of the termination of such policy or plan in the event an insurance company or health services corporation or health care plan cancels or refuses to renew an individual policy or plan or enrollee's participation in plan;
- If you are a North Carolina patient:
    - medical and nursing treatment that avoids unnecessary physical and mental discomfort and to be free from duplication of medical and nursing procedures as determined by the attending physician;
    - designate visitors who will receive the same visitation privileges as your immediate family members, regardless of whether the visitors are legally related to you;
    - not be awakened by hospital staff unless it is medically necessary;
    - when medically permissible, be transferred to another facility upon request; and
    - be informed upon discharge of your continuing health care requirements following discharge and the means for meeting them.
- If you are a Colorado patient:
    - Request an in-network healthcare provider provide services at an in-network facility or agency, if available.

Finances

You have a right to:

- Receive, upon request and prior to initiation of care or treatment, estimated average charges for non-emergent care, including deductibles and co-payments that would not be covered by a third-party payer based on the coverage information supplied by you or your representative;
- Receive our general billing procedures;
- Regardless of source of payment, to examine and to receive a reasonable explanation of your total bill for health care services rendered by your physician or other health care provider, including the itemized charges for specific health care services received; and
- If you are a Colorado or Georgia patient, receive within ten (10) business days of your request or thirty (30) days after your discharge or after service is rendered (whichever is later) an itemized bill that has a telephone number for billing inquiries and identifies the treatment and services by date that will enable you to validate the charges; and
- If you are a North Carolina patient, full information and counseling on the availability of known financial resources for your health care.

Privacy and Confidentiality

You have a right to:

- Personal privacy and confidentiality in health care (may be waived in writing);
- Confidentiality of your clinical records except as otherwise provided by law; and
- Access to information contained in your clinical records within a reasonable time frame.

Grievances

You have a right to:

- Be informed of the complaint procedures and the right to submit complaints, either orally or in writing, without fear of discrimination or retaliation and to have them investigated by your provider within a reasonable period of time;
- Be given the name, business address and telephone number of the person that will handle any complaints or questions about services being delivered to you;
- If you are a Georgia patient, receive a written notice of the address and telephone number of the Georgia licensing authority, which is charged with the responsibility of licensing our facility provider and investigating client complaints which appear to violate licensing regulations;
- If you are a Colorado patient, register complaints with us at the Colorado Health Facilities & Emergency Medical Services Division at https://docs.google.com/forms/d/e/1FAIpQLScLOLmW1TxB6ZqDcUivQkVOvtLHZc7OfXBEKDkgL-4valt22Q/viewform, or call the Colorado Department of Public Health & Environment at (303) 692-2827 or the appropriate oversight board at the Department of Regulatory Agencies (DORA); and
- Obtain a copy of our most recent completed report of licensure inspection upon written request.

Texas Minors

If you are a minor in Texas, you have a right to:

- Appropriate treatment in the least restrictive setting available;
- Not receive unnecessary or excessive medication;
- An individualized treatment plan and to participate in the development of the plan;
- A humane treatment environment that provides reasonable protection from harm and appropriate privacy for personal needs;
- Separation from adult patients; and
- Regular communication between you and your family.

Patient Responsibility

You have the responsibility to:

- Advise your provider of any changes in your condition or any events that affect your service needs.

Concerns or Complaints

Your satisfaction is important to us. If you have a concern or a complaint, please allow the person responsible for your care or their supervisor the opportunity to listen, review, and to assist you with an appropriate resolution. If your complaint is unresolved, please ask to speak to the department's manager, director or the house supervisor. If your concern cannot be resolved by the AdventHealth process indicated, please allow the facility the opportunity to address your grievance.

Colorado	Facility Contact Information
AdventHealth Avista	Patient Advocate
100 Health Park Dr, Louisville, CO 80027	303-661-4357
AdventHealth Castle Rock	Patient Advocate
2350 Meadows Blvd, Castle Rock, CO 80109	720-455-2531
AdventHealth Littleton	Patient Advocate
7700 South Broadway, Littleton, CO 80122	303-738-7781
AdventHealth Parker	Patient Advocate
9395 Crown Crest Blvd, Parker, CO 80138	303-269-4053
AdventHealth Porter	Patient Advocate
2525 South Downing Street, Denver, CO 80210	303-778-5685
Georgia	
AdventHealth Gordon	Patient Experience
1035 Red Bug Road, Calhoun, GA 30701	706-602-7800, ext. 2310
AdventHealth Murray	Patient Experience
707 Old Dalton Ellijay Road, Chatsworth, GA 30705	706-602-7800, ext. 7848
AdventHealth Redmond	Patient Advocate
501 Redmond Road, Rome, GA 30165	706-802-3898
Illinois	

UChicago Medicine Adventhealth Bolingbrook 500 Remington Blvd, Bolingbrook, IL 60440 UChicago Medicine Adventhealth GlenOaks 701 Winthrop Avenue, Glendale Heights, IL 60139 UChicago Medicine AdventHealth Hinsdale 120 N Oak Street, Hinsdale, IL 6052 UChicago Medicine AdventHealth La Grange 5101 S Willow Springs Rd, La Grange, IL 60525	Patient Liaison 630-856-6010
Kansas	
AdventHealth Ottawa 1301 Main Street, Ottawa, KS 66067	Chief Clinical Officer 785-229-8312
AdventHealth Shawnee Mission 9100 West 74th Street, Shawnee Mission, KS 66204	Patient Advocate 913-676-2155
AdventHealth South Overland Park 7840 W 165th Street, Overland Park, KS 66223	Patient Advocate 913-676-2155
AdventHealth Lenexa 23401 Prairie Star Parkway, Lenexa, KS 66227	Patient Advocate 913-676-2155
Kentucky	
AdventHealth Manchester 210 Marie Langdon Drive, Manchester, KY 40962	Patient Experience 606-598-5104 ext. 3183 or 3185
North Carolina	
AdventHealth Hendersonville 100 Hospital Drive, Hendersonville, NC 28792	Patient Experience 828-681-2781 or 828-687-5671
Texas	
AdventHealth Central Texas 2201 South Clear Lake Road, Killeen, TX 76549 AdventHealth Rollins Brook 608 North Key Avenue, Lampasas, TX 76550	Patient Advocate Department 254-519-8553 OR TTY number: 877-746-4674
Texas Health Huguley 11801 South Freeway, Burleson, TX 76028	Patient Advocate 817-551-2495
Texas Health Mansfield 2300 Lone Star Road, Mansfield, TX 76063	Patient Advocate 682-341-5255
Wisconsin	
AdventHealth Durand 1220 Third Avenue, West, Durand, WI 54736	Patient Experience 715-672-4211

Additionally, if your concern has not been resolved, you may reach out to the AdventHealth Corporate Risk Management team, 407-357-2290, 900 Hope Way, Altamonte Springs, Florida 32714. Most issues will be resolved in 30 days or less.

The following state agencies may be contacted:

State/Facility	Licensing Agency	Accreditation Agency
Colorado AdventHealth Avista | 100 Health Park Dr, Louisville, CO 80027 AdventHealth Castle Rock | 2350 Meadows Blvd, Castle Rock, CO 80109 AdventHealth Littleton | 7700 South Broadway. Littleton, CO 80122 AdventHealth Parker | 9395 Crown Crest Blvd, Parker, CO 80138 AdventHealth Porter | 2525 South Downing Street, Denver, C 80210	The Colorado Department of Public Heath and Environment 4300 Cherry Creek Drive South Denver, CO 80222-1530 303-692-2827	Joint Commission: E-mail: complaints@jointcommission.org Fax: Print a Quality Incident Report Form from the web site, www.jointcommission.org, and fax to the Office of Quality Monitoring, Fax: 630-792-5636 Mail: Print form as above and mail to: Office of Quality Monitoring The Joint Commission One Renaissance Boulevard Oakbrook Terrace, IL 60181
Georgia AdventHealth Gordon | 1035 Red Bug Road, Calhoun, GA 30701 AdventHealth Murray | 707 Old Dalton Ellijay Road, Chatsworth, GA 30705 AdventHealth Redmond | 501 Redmond Road, Rome, GA 30165	Georgia Office of Regulatory Services Two Peachtree Street, NW Atlanta, GA 30303-3142	
Illinois UChicago Medicine Adventhealth Bolingbrook | 500 Remington Blvd, Bolingbrook, IL 60440 UChicago Medicine Adventhealth GlenOaks | 701 Winthrop Avenue, Glendale Heights, IL 60139 UChicago Medicine AdventHealth Hinsdale | 120 N Oak Street, Hinsdale, IL 6052 UChicago Medicine AdventHealth La Grange | 5101 S Willow Springs Rd, La Grange, IL 60525	Illinois Department of Public Health 122 S Michigan Ave Ste. 700 Chicago, IL 60603 800-252-4343 TTY: 800-547-0466	
North Carolina AdventHealth Hendersonville | 100 Hospital Drive | Hendersonville, NC 28792	N.C. Division of Health Services 800-624-3004	

Texas Texas Huguley ASC AdventHealth Central Texas 2201 South Clear Lake Road, Killeen, TX 76549 AdventHealth Rollins Brook | 608 North Key Avenue, Lampasas, TX 76550 Texas Health Huguley | 11801 South Freeway, Burleson, TX 76028 Texas Health Mansfield | 2300 Lone Star Road, Mansfield, TX 76063	Texas Department of State Health Services 1100 West 49th Street Austin, TX 78756 Office of the Ombudsman PO Box 13247 Austin, TX 78711-3247 877-787-8999
Kansas AdventHealth Ottawa | 1301 Main Street, Ottawa, KS 66067 AdventHealth Shawnee Mission | 9100 West 74th Street, Shawnee Mission, KS 66204 AdventHealth South Overland Park | 7840 W 165th Street. Overland Park, KS 66223 AdventHealth Lenexa | 23401 Prairie Star Parkway, Lenexa, KS 66227	Kansas Division of Public Health 1000 SW Jackson, Suite 540 Topeka, KS 66612
Wisconsin AdventHealth Durand | 1220 Third Avenue, West Durand, WI 54736	Wisconsin Department of Health Services 1 West Wilson Street Madison, WI 53703
Kentucky AdventHealth Manchester | 210 Marie Langdon Drive, Manchester, KY 40962	Kentucky Cabinet for Health and Family Services 275 East Main Street, 5E-A, Frankfort, KY 40621

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, including a hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs,like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your healthplan to provide services. Out-of-network providers may be allowed to bill you for the differencebetween what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for thesepost-stabilization services.

Please see the information regarding Illinois law below.

Certain services at an in-network facility, including a hospital or ambulatory surgical center

When you get services from an in-network facility, including a hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protectionsnot to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

Please see below for information regarding Illinois law.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance,and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay anin-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

Illinois Law: Illinois law generally contains balance billing protections similar to those under the No Surprises Act (as described in this Notice), for individuals with Illinois Department of Insurance-regulated plans (i.e., preferred provider organization ("PPO") plans and health maintenance organization ("HMO") plans). If receiving services in a hospital, note that you may receive separate bills for services provided by providers affiliated with the hospital, some of which may not be participating providers in the same insurance plans and networks as the hospital. As explained in this notice, you may have a greater financial responsibility for services provided by providers at the hospital who are not under contract with your insurance plan. If you are unsure whether you have one of these plans or if you have questions about coverage or benefit levels, call your insurance carrier.

If you think you've been wrongly billed, contact the HHS No Surprises Helpdesk at 1-800-985-3059, which is the entity responsible for enforcing the federal balance or surprise billing protection laws. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Illinois also has an independent dispute resolution process to resolve claims-related issues, including disputes between your provider or insurance plan pertaining to receipt of improper balance bills. If you are an Illinois Department of Insurance enrollee and you think you've been wrongly billed by your health insurer, you may submit an online complaint at https://www2.illinois.gov/sites/Insurance/Consumers/Pages/File-a-complaint.aspx or call (866) 445-5364. If you believe you received an improper balance bill from your health care provider, you may also file a complaint with the Illinois Attorney General's Health Care Bureau at https://www.illinoisattorneygeneral.gov/consumers/healthcare.html or call (877) 305-5145.

Patient Name: _____

MRN: _____

Date of Birth: _____

UChicago Medicine AdventHealth Treatment and Consent Agreement

Version 5.0 Updated 01/01/2025

Adventist Midwest Health does business as "UChicago Medicine AdventHealth" and operates facilities including, but not limited to, hospitals, outpatient centers, medical groups, and other locations (referred to all together in this document as "UChicago Medicine AdventHealth"). Many of these facilities are separate legal entities. You may ask us for a list of UChicago Medicine AdventHealth entities. This UChicago Medicine AdventHealth Treatment and Consent Agreement ("Agreement") may be signed one time each year to provide consent for treatment at all these UChicago Medicine AdventHealth facilities, unless you tell us you want to sign a new form at your appointment, or we update this form. This Agreement must be signed by the Patient or by the Patient's Legal Representative acting for the Patient (for example, a parent signing for their minor child). All references to "I", "me", "my", "you" and "your" refer to the Patient.

CONSENT TO TREATMENT:

1. **Services.** I consent to diagnostic and treatment procedures, examinations and laboratory procedures or inpatient admission, prescribed medications or other items ("Services") needed for my treatment during my admission to or treatment at UChicago Medicine AdventHealth by doctors ("Physicians"), and other medical professionals, residents, students, integrated physician networks, health plan networks, and UChicago Medicine AdventHealth employees, contractors, and personnel (collectively "Care Providers"). I understand I will be told about my treatment and will be able to ask questions about the risks, options and hoped for outcome of the treatment before I let the treatment be done. I agree that no promises have been given to me as to the outcome of any treatment.
2. **Photography.** I consent to photographs, video monitoring or audio recordings being taken of me for verifying my identity and/or my treatment.
3. **Video Visits.** If I want to schedule a Video Visit or if my Physician thinks a Video Visit will work best for my care, I consent to be treated through electronic communications online that will connect me with my Physician or Care Provider in another location. I understand that during a Video Visit there is a risk of technical failures beyond the control of UChicago Medicine AdventHealth which could make the images harder to see correctly, or cause my health record to be breached or not accessible, or delay my treatment. I also understand that a Video Visit may be more efficient and allows me to stay at home for treatment or be treated by a distant specialist. I understand that other persons may be present during the Video Visit.

4. **Independent Contractors.** The following providers are all independent contractors and are not employees or agents of UChicago Medicine AdventHealth: Emergency Medicine Physicians, Radiologists, Pathologists, Hospitalists, Pulmonologists, Pediatricians, and Neonatologists, including their Physician Assistants and Advanced Practice Registered Nurses.

   Within other specialties, such as Surgery, Anesthesiology, Obstetrics & Gynecology, Neurology, and Cardiology, the Physicians, Physician Assistants and Advanced Practice Registered Nurses are also independent contractors and are not employees or agents of UChicago Medicine AdventHealth unless they have explicitly identified themselves as employees of UChicago Medicine AdventHealth.

   Independent Contractors:

   - Are not employees or agents of UChicago Medicine AdventHealth;
   - Use their own independent medical judgment and are responsible for their own actions; and
   - Bill patients separately for the services they provide at the hospital, as permitted by law.

   UChicago Medicine AdventHealth does not pay for the errors or mistakes or failures to act by any independent contractors.

   When I am treated at a UChicago Medicine AdventHealth Hospital, I confirm my understanding that:

   (a) All independent contractors as stated above are independent; this means that they are not employees or agents of UChicago Medicine AdventHealth; and

   (b) All independent contracts as stated above will bill me separately for the care they give me at the hospital, as permitted by law.

   I promise that:

   (c) The employment or agency status of the Physicians, Physician Assistants and Advanced Practice Registered Nurses is not part of and does not affect my decision to seek hospital care at UChicago Medicine AdventHealth;

   (d) I have not based my decision to seek hospital care at UChicago Medicine AdventHealth on any representation, advertising or promotional information from UChicago Medicine AdventHealth that the Physicians, Physician Assistants or Advanced Practice Registered Nurses treating me are employees or agents of UChicago Medicine AdventHealth and

   (e) I have read and understand this section and will ask my Physicians, Physician Assistants and Advanced Practice Registered Nurses any questions I have about their independent contractor or employment status.

5. **Patient Rights.** I understand a copy of UChicago Medicine AdventHealth's Patient Rights and Responsibilities information will be offered to me as required by law.

6. **Advance Directives.** I have been able to tell UChicago Medicine AdventHealth about my current choices for Advance Directives by filling out a new form or giving them a copy of my earlier Advance Directives. UChicago Medicine AdventHealth, Physicians and Care Providers are not required to follow Advance Directives they do not know about. Please select which option(s) below applies to you:
   - ☐ I am under 18 years of age and have no Advance Directives.
   - ☐ I have Advance Directives and I have given a copy to UChicago Medicine AdventHealth
   - ☐ I have Advance Directives, but I have not given UChicago Medicine AdventHealth a copy. I understand I must give UChicago Medicine AdventHealth a copy.
   - ☐ I do not have Advance Directives.
   - ☐ I would like information about Advance Directives.
7. **Legal Representative.** I have been able to tell UChicago Medicine about my current choice for my Legal Representative by giving them a copy of my legal documents outlining my decision. UChicago Medicine AdventHealth, Physicians and Care Providers are not required to involve my Legal Representative in my treatment if they do not know who my Legal Representative is or if there are changes to this delegation they do not know about. I understand that I am responsible to tell UChicago Medicine AdventHealth, Physicians and Care Providers when I change my Legal Representative, or when the powers of the Legal Representative end.
8. **Personal Property/Valuables.** Where applicable, I will give any personal property or valuables to UChicago Medicine AdventHealth for storage in a secure location if I want to ensure my personal property and valuables are safe. UChicago Medicine AdventHealth shall not be liable in any event for loss or damage to personal property or valuables in excess of $100. I release UChicago Medicine AdventHealth from liability for any personal property or valuables that are not given to UChicago Medicine AdventHealth for safe-keeping.

CONSENT TO PAYMENT:

1. **Payment.** I, or (where permitted by law) my Legal Representative signing this Agreement for me, must pay for the Services received during my treatment today and any related future Services provided by UChicago Medicine AdventHealth, Physicians and Care Providers ("Account"), including any required co-pays, with cash, check, credit card and/or insurance. I under- stand that no credit is being given to me and that the Account is due and payable right away. **If I cannot pay my Account in full when due, UChicago Medicine AdventHealth's Financial Services Office will determine if I qualify for any financial assistance.** If I do not pay for all my Services and UChicago Medicine AdventHealth sends my Account to an attorney or collection agency, I agree to pay the attorneys' fees and collection expenses as permitted by law up to 25% of the money I owe.
2. **Credit Card Payments.** If I pay for the Services with my credit card, I certify that I am the credit card holder and authorize payment of the Services.

3. **Insurance Payments and Assignment of Benefits.** If I am entitled to benefits under: (i) the Medicare program, the Medicaid program, other kinds of government insurance (the "Program"); (ii) Employee Retirement Income Security Act ("ERISA") health benefit plans; or (iii) any insurance policy or other health benefit plan (covering me or anyone legally responsible for me) or from any other source (the "Benefit Plan"), including as a result of injuries sustained by me, in consideration for admission to and/or for Services provided to me by UChicago Medicine AdventHealth, Physicians and Care Providers, which includes independent contractors, I irrevocably assign, transfer and convey the Program and Benefit Plan benefits payable and all right, title and interest in and to such benefits, compensation or payment received or to be received for the Services provided to me by UChicago Medicine AdventHealth, Physicians and Care Providers (collectively "Benefits") to UChicago Medicine AdventHealth, Physicians, Care Providers, and their assignees. I irrevocably authorize payment of my Benefits directly to UChicago Medicine AdventHealth, Physicians, Care Providers and their assignees, to be applied to my Account.

   I understand that assigning my payment of Benefits will not relieve me of obligations to pay UChicago Medicine AdventHealth, Physicians, Care Providers, and their assignees, for charges that are not covered by this assignment. If assignment or direct payment is not permitted, I agree to direct my Benefit Plan to make checks or drafts jointly payable to (i) the beneficiary or covered person and (ii) UChicago Medicine AdventHealth,

   Physicians, Care Providers, or their assignees, and to send payment to me in care of UChicago Medicine AdventHealth, Physicians, Care Providers, or their assignees. I also give permission for UChicago Medicine AdventHealth, Physicians and Care Providers to seek payment in full for charges from parties who injure me or others who may be obligated to pay for my care and their insurers even if Benefits are payable by a managed care payer on my behalf. I agree to pay the difference between the amount my insurance pays and UChicago Medicine AdventHealth, Physicians or Care Providers' charges (as limited by law or contract) except when UChicago Medicine AdventHealth, Physicians or Care Providers have a contract(s) with a Benefit Plan that will not let them collect that difference from me and/or the subscriber. If my Benefit Plan includes a self-funded/insured plan under ERISA or other type of Benefit Plan, in order to help me get my Benefits:

   I irrevocably authorize and appoint UChicago Medicine AdventHealth, Physicians, Care Providers or their assignees to be my representative and attorney-in-fact, when Advent-Health, Physicians, Care Providers or their assignees agree in writing to so act in taking all actions needed to get payment, appealing any adverse benefit determination or requesting any reconsideration and to receive notices on my behalf for this purpose. I will follow the procedures required by ERISA or my Benefit Plan for this authorization, if any.

4. **Honesty and Cooperation Statement.** I promise that my (i) payment sources and insurance coverage information and (ii) any completed insurance applications are true and correct to the best of my knowledge. I agree to give my insurance or financial assistance information timely. I agree to pay all charges that could have been filed if deadlines are missed due to my dishonesty or non-cooperation.

5. **Consumer Report Consent.** I authorize UChicago Medicine AdventHealth, Physicians and Care Providers, or their assignees, to get consumer reports about me from one or more consumer reporting agencies to assist AdventHealth, Physicians and Care Providers, or their assignees, with their business activities related to billing, collecting, instituting payment

arrangements, and/or determining eligibility for uncompensated care and/or government programs for past, current or upcoming Services at the hospital or outpatient center (whether or not such Service did, may, or will involve an extension of credit) or to resolve any outstanding Account balances. I understand UChicago Medicine AdventHealth, Physicians and Care Providers or their assignees may obtain consumer reports about me for Services at the hospital or outpatient center without my written permission under some circumstances as permitted by law. Consumer reports will not be pulled for Services provided at UChicago Medicine AdventHealth Medical Group locations.

6. **Credit Balances.** I give permission to apply any credit balances to pay for amounts due to UChicago Medicine AdventHealth, Physicians, and Care Providers for current Accounts or accounts I have not paid yet.
7. **Hospital Laboratory Bills**. Testing of fluids/specimens in UChicago Medicine AdventHealth's laboratory at the hospital is performed under the supervision of a Physician (i.e., pathologist) who may not perform the test or review results, but who does supervise and monitor reporting of the laboratory test results to ordering Physicians. As permitted by law, I AUTHORIZE PAYMENT BY MY BENEFITS FOR THE PHYSICIAN/PATHOLOGIST SUPERVISORY SERVICES. I understand I will not be billed for these supervisory services at the UChicago Medicine AdventHealth laboratory if my Benefits deny reimbursement.

CONSENT TO SHARING HEALTH INFORMATION:

I give consent to UChicago Medicine AdventHealth, Physicians and Care Providers to share the following health information as permitted by law and described below:

a. **What Health Information?** My name, address, contact information, financial information, diagnoses, treatment information which includes HIGHLY CONFIDENTIAL SUBSTANCE ABUSE, MENTAL HEALTH AND HIV/AIDS INFORMATION AS WELL AS INFORMATION IDENTIFIED IN THE UCHICAGO MEDICINE ADVENTHEALTH JOINT NOTICE OF PRIVACY PRACTICES AS SUBJECT TO SPECIAL STATE LAWS, and any other information that is part of my health record with UChicago Medicine AdventHealth.

b. **For What Purposes?** Treatment, payment, and health care operations and as further described in the UChicago Medicine AdventHealth Joint Notice of Privacy Practices.

c. **To Whom?**

- Any person or entity responsible for (i) paying for or determining if I am eligible for payment for my treatment or for assigning my Benefits, and (ii) their healthcare operations.
- Physicians or Care Providers or my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, hospice, government or private agency which may provide medical, mental health, rehabilitation, social or related Services to me during a visit with, or during or upon my discharge or transfer from a UChicago Medicine AdventHealth facility.
- Physicians who have not treated me at UChicago Medicine AdventHealth, but who have my written permission to access my health information.

- Business partners (and their agents and vendors used to provide the services) of UChicago Medicine AdventHealth, Physicians or Care Providers who provide administrative, operational, financial, billing and collection, legal and technical support services.
- UChicago Medicine AdventHealth's affiliates, which are other entities owned or managed by UChicago Medicine AdventHealth or other physicians who are part of integrated physician or plan networks.
- UChicago Medicine AdventHealth's institutionally related foundation for fundraising purposes, but only when I have received treatment at the hospital and then only my name, address, contact information, age, gender, dates of services, health insurance status, department where services were provided in the hospital, treating physician(s), and outcome information.
- Recipients who are required or permitted by law to have access to my health information.

d. How Will It Be Shared? Hand delivery, mail, and electronically such as but not limited to electronic mail, facsimile, and through health information exchanges. Health information exchanges are entities that store and/or transfer health information electronically among providers to treat patients. This consent means that UChicago Medicine AdventHealth, Physicians and Care Providers may access my health information through health information exchanges and share my health information with other health care providers through health information exchanges. I understand that my highly confidential information will be part of my health information shared or accessed.

e. Can I Stop Sharing My Health Information? Please review the UChicago Medicine AdventHealth Joint Notice of Privacy Practices and ask UChicago Medicine AdventHealth for the Request to Restrict Use and Disclosure of Protected Health Information form.

_____ (Initial Here) I give consent to UChicago Medicine AdventHealth, Physicians and Care Providers to use, share and access my health information as permitted by law and described above.

CONSENT TO CONTACT:

By signing this Agreement, I understand that I am giving permission to UChicago Medicine AdventHealth, Physicians, and Care Providers, and their independent contractors, agents, and assignees to call me and send messages (for example, text messages, emails, and chat messages etc.) to me at any time, at any telephone number, including any current or subsequently obtained cellular or wireless number that I am a user or subscriber of, that is provided by me or given to UChicago Medicine AdventHealth by a third party helping UChicago Medicine AdventHealth collect my debt, by using an automatic telephone dialing system or an artificial or prerecorded voice for any purpose related to my healthcare and treatment, including prescription refill and appointment reminders, billing or collecting payment for my care (including financial assistance options), recommending possible treatment options or health-related benefits and services, and transportation arrangements. Consent to contact you for payment as described above continues until you tell us to cancel your consent or you make payment in full or UChicago Medicine AdventHealth, Physicians or Care Providers waive or cancel your payment.

You may opt out of receiving certain types of text messages from UChicago Medicine AdventHealth at any time by texting STOP each time a message is sent to you from us. You may also select certain communication choices within the AdventHealth app. You may contact UChicago Medicine AdventHealth at any time to opt out of receiving auto-dialed or pre-recorded voice calls. UChicago Medicine AdventHealth reserves the right to have a UChicago Medicine AdventHealth staff member personally call you at any time about your treatment or payment for our Services.

EFFECTIVE PERIOD:

_____ (Initial Here) I understand this Agreement is effective during the calendar year I sign it and until I sign it again.

ANY HANDWRITTEN CHANGES TO THIS FORM SHALL NOT BE LEGALLY BINDING OR ENFORCEABLE. I HAVE READ THIS AGREEMENT OR HAVE HAD IT READ TO ME. IT HAS BEEN EXPLAINED TO MY SATISFACTION:

DATE: _____ TIME:_____ Signature:_____

IF THE SIGNATURE ABOVE IS NOT THE PATIENT'S, WRITE THE NAME AND RELATIONSHIP OF THE PERSON SIGNING FOR THE PATIENT BELOW:

DATE: _____ TIME:_____ Relationship:_____

(e.g., Parent, Guardian, Health Care Surrogate, Guarantor, Proxy, Power of Attorney)

Printed Name: _____

EMPLOYEE SIGNATURE IF PATIENT OR LEGAL REPRESENTATIVE IS NOT ABLE/UNWILLING TO SIGN:

Reason Patient Unable/Unwilling To Sign:_____

_____

DATE: _____ TIME:_____ Signature:_____

IF INTERPRETER SERVICES ARE USED:

DATE: _____ TIME:_____ Signature:_____

Please write the interpreter name, badge ID number, language translated, method of translation (phone, video, or in-person), and interpreter signature if translation is in-person.

Advance Directives
Making your Wishes Known

It is vital for your health care providers and family to know what is most important to you so we can honor your wishes. **Advance Directives** guide others to make medical care decisions you would make for yourself if you are unable to speak for yourself. This packet provides general information and Advance Directive forms to complete, which includes a Health Care Surrogate Designation form and a Living Will.

What do I do after completing my Advance Directive form?

- It is very important that you discuss your wishes and medical care with your Health Care Surrogate, family, and health care providers so they can honor your wishes.
- Share copies of this form with your Health Care Surrogate, doctors, nurses, caregivers, family, and friends as appropriate.
- Keep a copy for yourself that someone can easily find.
- Consider reviewing your forms every few years and during any major health event because your wishes may change.

What if I change my mind?

- You can change your mind at any time.
- Your spoken wishes about medical treatment must be honored even if different from your forms.
- If your wishes change it is best to fill out a new form and update your Health Care Surrogate and medical team.

Please talk to your physician, clergy, or attorney if you have further questions.

The **Health Care Surrogate** is a person you trust and name to make medical decisions when you are too sick to make your own decisions or are able to make decision but would like your surrogate to make medical decisions on your behalf. Your Health Care Surrogate should make decisions guided by your Living Will. In some situations, your Health Care Surrogate will be asked to make decisions based on your best interest. Often family members are good choices, but not always.

When you choose a Health Care Surrogate consider:

- Someone who is 18 years of age or over and is mentally competent to make decisions.
- Someone who understands your personal, social, and spiritual values and will advocate for you.
- Someone who will honor and advocate for your wishes even if they are different from their own.
- Someone who will be available and can work well with the medical team.
- Someone who can handle stressful family situations.

What if I do not choose a Health Care Surrogate?

If you are too sick to make your own decisions and you do not name a Health Care Surrogate, your Next of Kin will be your decision maker which would include the following, in the highest order of priority:

1. Spouse
2. Adult children
3. Parent(s)
4. Adult sibling(s)
5. Adult relative(s)
6. Close personal friend (by notarized affidavit)

Patient Label

Designation of Health Care Surrogate Form

In the event that I, (full name) _____, am no longer able to make my own health care decisions, I choose as **my Health Care Surrogate**:

Name: _____/_____ _____
First Name Last Name Phone #

Address: _____

If my Health Care Surrogate is unwilling or unable to perform these duties, I choose as **my alternative Health Care Surrogate**:

Name: _____/_____ _____
First Name Last Name Phone #

Address: _____

My Health Care Surrogate's authority becomes effective when my physician(s) determine that I am unable to make my own health care decisions.

Optional: I also have the option to choose that my Health Care Surrogate's authority become **effective immediately** even while I am competent by initialing either or both of the following boxes:

I MUST initial:

_____ My Health Care Surrogate has authority to receive my health information while I'm competent.
Initial

_____ My Health Care Surrogate has authority to make health decisions for me even while I am
Initial competent. However, any instructions or health care decisions I make, either verbally or in writing, will supersede any instructions or health care decisions made by my Health Care Surrogate while I have the capacity to do so.

Specific instructions or restrictions:_____

I authorize my health care surrogate to make all health care decisions for me, which means he or she has the authority to:

- Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
- Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
- Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
- Decide to make an anatomical gift.

My Signature:_____ **Date:**_____/_____/_____ **Time:** _____

_____ _____
1st Witness (required): **2nd Witness (required)**:

Witness Signatures: Two required. Your Health Care Surrogate **cannot** be a witness. Only one witness can be your family or spouse. You do not need a notary.

☐Phone
_____OR ☐Video _____ _____ _____
Qualified Staff / Interpreter Signature (Check) Print Qualified Staff / Interpreter Name ID Number Language Interpreted

Patient Label

LIVING WILL INFORMATION

The **Living Will** lets your health care team, family and others know your wishes regarding life support treatment and how to apply them to your medical care. **Life support treatments** are used when you are very sick. These treatments are often helpful, but in certain situations can only add to suffering and prolong the dying process. The difference between prolonging life and prolonging suffering depends on your values about what makes life worth living. Often when you are so sick that you may die soon you are unable to speak for yourself. This part helps you keep a 'voice' in your care when you are not able to speak.

Life support treatments may include, but are not limited to, **medicines, surgeries, invasive procedures**, such as:

- **Intubation with a breathing machine or ventilation**: when a tube is placed through your mouth to your lungs, or a tracheostomy tube in your neck, so that a machine can pump air into your lungs and breathe for you.
- **Artificial feeding:** this would include a feeding tube or TPN (IV nutritional support) if you cannot swallow.
- **IV Fluids**: for hydration and administration of medications
- **Blood transfusions**: to put other blood or blood products into your veins
- **Dialysis**: a machine that cleans your blood if your kidneys stop working

LIVING WILL FORM

My wish is if I am very sick: (Initial **EITHER** Section I or II below)

Section I. I do not want any life support treatment if I am in a: (initial all that apply)

_____ *Initial* **Persistent Vegetative State**: a permanent condition of unconsciousness, meaning you cannot interact with the world and have no voluntary actions or thinking behavior.

_____ *Initial* **End Stage Condition**: an irreversible condition that causes severe worsening and permanent decrease in health where treatment would not likely work.

_____ *Initial* **Terminal Condition**: a condition where there is likely no probability of recovery and it is expected to cause death without treatment.

I do _____ (*initial*) **or I do not** _____ (*initial*) want to be given nutrition and / or hydration artificially by a feeding tube or by intravenous feedings when it would serve only to prolong artificially the process of dying.

I willfully and voluntarily make known my desire that my dying not be artificially prolonged under the above initialed circumstances. I request to be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain

OR

Section II.

_____ *Initial* **I do want to try** the life support treatments my physician thinks might help. If the treatments **do not work** and there is little hope of getting better, **I do not want** to stay on life support machines.

Additional Instructions (Optional): _____

I request that my Living Will be honored by my family and medical team and I accept the consequences of my choices. I am thinking clearly.

My Signature:_____ **Date**:_____/_____/_____ **Time**: _____

_____ _____

1st Witness (required): **2nd Witness (required)**:

Witness Signatures: Two required. Only one witness can be your family or spouse. You do not need a notary.

_____ OR ☐ Phone ☐ Video _____ _____ _____

Qualified Staff / Interpreter Signature (Check) Print Qualified Staff / Interpreter Name ID Number Language Interpreted

Patient Label

ADDITIONAL IMPORTANT INFORMATION REGARDING YOUR WISHES TO SHARE WITH YOUR HEALTH CARE TEAM AND HEALTH CARE SURROGATE / FAMILY

A Living Will is NOT a "Do Not Resuscitate" (DNR) order.

If you do not want Cardiopulmonary Resuscitation (CPR) in the event you have a cardiac or respiratory arrest, you will need to speak to your physician to order a "Do Not Resuscitate" (DNR) (Allow Natural Death) order. A specific "DNR order" is required which tells the medical team how to treat you in the event your heart and / or lungs stop working. It does **not** mean "Do Not Treat" before your heart/lungs stopped. If you are a patient, you will receive care and treatment recommended by your physician and agreed upon by you. Please talk with your health care provider about your current medical condition as well as the benefit and harm of each treatment option.

Cardiopulmonary Resuscitation (CPR) is an attempt to resume your heart and lung function if your heart or lungs stop working. CPR may include:

- Chest compressions – pressing in a hard-repetitive motion on your chest to attempt to keep your blood flowing
- Defibrillation - Electric shocks to attempt to restart your heart
- Medicines in your veins
- Intubation with a breathing machine or ventilation

If CPR is successful, you usually would be in the Intensive Care Unit on a breathing machine and other treatment therapies, if needed.

If you decide you do not want CPR measures taken in the event of a cardiac and/or respiratory arrest, you (or your health care surrogate or next of kin on your behalf if you are unable to make medical decisions) will need to sign a separate "Do Not Resuscitate" (DNR) Order form. There are two types of DNR forms, hospital specific and community. Your health care provider can provide you more information regarding the most appropriate DNR order form for use based on your wishes.

If you are a patient in the hospital, speak with your physician regarding having a Do Not Resuscitate Order form completed.

If you are in the community, you may download and print the State of Florida Do Not Resuscitate Order form. You may access the form at http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/do-not-resuscitate/index.html. This form must be printed on yellow paper and signed by yourself and your physician to be honored by the community Emergency Medical Services.

Patient Label

Patient Nondiscrimination in Health Care Services
Affordable Care Act Section 1557

AdventHealth complies with all applicable federal civil rights laws, including Section 1557 of the Affordable Care Act (Section 1557). AdventHealth does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)).

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

Language assistance services. AdventHealth will provide language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Please notify your provider of language assistance service requests when scheduling your appointment to ensure we have the appropriate resources available when you arrive.
Language assistance services may include:

- Electronic and written translated documents
- Qualified interpreters
- Qualified bilingual/multilingual staff

Appropriate auxiliary aids and services. AdventHealth will provide appropriate auxiliary aids and services for individuals with disabilities (including individuals' companions with disabilities) to ensure effective communication. Appropriate auxiliary aids and services may include:

- Qualified interpreters, including American Sign Language interpreters
- Video remote interpreting
- Information in alternate formats (including but not limited to large print, recorded audio and accessible electronic formats)

Reasonable modifications. AdventHealth will provide reasonable modifications for qualified individuals with disabilities when necessary, to ensure accessibility and equal opportunity to participate in our programs, activities, services or other benefits.
To learn more about your rights as a patient, please refer to AdventHealth's Patient Rights and Responsibilities and this notice.

For additional assistance, you may also contact your provider's scheduling team or AdventHealth at 1-800-609-5964 (TTY: 711) or email PatientNondiscrimination@AdventHealth.com.

If you believe AdventHealth has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, sex, age or disability, you can:

1. File a grievance with AdventHealth Section 1557 Coordinator.
   Please call 1-800-611-4208 (TTY: 711) or email PatientNondiscrimination@AdventHealth.com.
2. File a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Electronically: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Via mail: U.S. Department of Health & Human Services
200 Independence Avenue, S.W. – 509F
Washington, D.C. 20201

To access this notice in additional languages, please visit https://www.adventhealth.com/legal/patient-nondiscrimination or scan the QR code.

AdventHealth

The statements below direct people whose primary language is not English to translation assistance.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-609-5964 (TTY: 711) o hable con su proveedor.

注意：如果您說中文，我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供信息。致電 1-800-609-5964 (文本电话：711) 或諮詢您的服務提供商。

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các dịch vụ và phương tiện hỗ trợ bổ sung phù hợp để cung cấp thông tin bằng định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-609-5964 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd aladispozisyon w gratis pou lang ou pale a. Èd ak sèvis siplemantè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-800-609-5964 (TTY: 711) oswa pale avèk founisè w la.

주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-609-5964 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-609-5964 (TTY: 711) lub porozmawiaj ze swoim dostawcą.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتقديم المعلومات بطرق يسهل استخدامها مجانًا. اتصل على الرقم (711) 1-800-609-5964 أو تحدث مع مقدم الخدمة الخاص بك.

ВНИМАНИЕ: если вы говорите на русском языке, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-609-5964 (TTY: 711) или обратитесь к своему поставщику услуг.

ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Recursos e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-609-5964 (TTY: 711) ou fale com seu provedor.

À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le TTY : 1-800-609-5964 (TTY: 711) ou parlez à votre prestataire.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo ng tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang makapagbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-609-5964 (TTY: 711) o makipag-usap sa iyong provider.

ध्यान दिनुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने तपाईंका लागि भाषासम्बन्धी निःशुल्क सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-800-609-5964 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुराकानी गर्नुहोस्।

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-609-5964 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-609-5964 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિનામૂલ્યે ઉપલબ્ધ છે. 1-800-609-5964 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎቶች በነፃ ይቀርቡልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎችና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 1-800-609-5964 (TTY: 711) ይደውሉ ወይም የአገልግሎት አቅራቢዎን ያነጋግሩ።

УВАГА: якщо ви розмовляєте українською мовою, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-800-609-5964 (TTY: 711) або зверніться до свого постачальника.

25-CORP-01534

Understanding Your Emergency Room Cost

When you visit the emergency room, your health and safety are our top priorities. We also understand that concerns about unexpected medical bills can add stress during an already difficult time. That's why we're committed to being clear and supportive when it comes to your billing and insurance information. Every situation is unique, and our team is here to help you understand your coverage and explore your options.

Why Are We Asking for Payment?

At the time of your ER visit, we may ask for payment or provide you with an estimate based on your insurance coverage. This is a standard part of the registration process and helps:

Meet Insurance Requirements:

Many insurance plans require a copay or deductible to be collected at the time of service.

Avoid Surprise Bills with Estimate Transparency:

By getting payment information in advance, we can provide transparency throughout the billing cycle and more accurately bill your insurance, preventing delays.

Cost Transparency:

We'll help you understand your estimated out-of-pocket costs upfront.

What You Might Be Asked to Pay:

Depending on your situation, we may request:

- **Insurance co-payments**
- **Deductible or coinsurance estimates**
- **A deposit** if you do not have insurance

What if you can't make a payment? We have options for you:

We never delay emergency care due to an inability to pay. If you're unable to make a payment:

- You will **still receive medical treatment**
- We can **discuss flexible payment options**
- **Financial assistance** may be available for those who qualify

Please let our staff know if you have questions orneed help navigating your options.

Questions About Billing or Insurance?

Our Consumer Access and Patient Financial Services teams are here to help.

- Call: 855-AH1-BILL (855-241-2455).
- Visit: https://www.adventhealth.com/pay-my-bill
- Ask for a Financial Counselor on site

Thank you for choosing AdventHealth to care for you. We're dedicated to helping you feel whole, in body, mind and spirit.

AdventHealth