



CONDREAT

**CONDITIONS FOR TREATMENT AND
FINANCIAL RESPONSIBILITY**

Side 1 of 2

Any reference to “ChristianaCare” in this consent includes actions by ChristianaCare, its employees, contractors, and associated medical providers. Unless I otherwise withdraw my consent in writing, I consent to the following:

CONSENT FOR TREATMENT

- A. ChristianaCare may obtain my health and insurance coverage information, including my healthcare treatment and prescription history, and provide health services to me. I understand and agree that there is no guarantee of any specific outcome of health care services provided. I understand this consent applies to inpatient and outpatient hospital-based services, as well as all ambulatory office-based services I obtain from ChristianaCare.
- B. ChristianaCare is a teaching institution and professional trainees may participate in my care.
- C. ChristianaCare may use photographic, video, electronic, or audio media during or as part of some treatments (e.g., trauma, infant resuscitation) for performance improvement, patient identification, training and/or treatment purposes and this may be recorded. I understand that these recordings may be reviewed by the healthcare professionals but will not become a part of the medical record and will be erased after review.

TELEHEALTH

- A. I understand that “telehealth” (which includes “teletherapy” and other behavioral health services) is the mode of delivering health care services using digital communication technology to help evaluate, diagnose, consult, educate, monitor, and manage care and treatment without being in the same physical location as my provider.
- B. I understand that a telehealth visit is not the same as an in-person visit because I will not be in the same room with my provider. I understand that the quality of the digital connection may affect my provider’s ability to care for me through telehealth. I understand that I will not be treated through telehealth unless my condition supports the use of this technology as my provider will not be able to perform some aspects of a full physical examination.
- C. I understand that digital communication technology may include, but not be limited to real time two-way audio, video, or other telecommunications or electronic communications, including remote patient monitoring, secure video conferencing, and/or secure texting with my care team.
- D. I understand that there are benefits to utilizing telehealth services, which include, but are not limited to, convenient medical evaluation and management. I also understand that there are risks involved in receiving treatment through telehealth, which include, but are not limited to interruption in the audio/video connection that may result in the visit being postponed until a later time and/or performed through an alternate method, and, in rare cases, unauthorized access to my confidential information. I understand that while I am receiving care through telehealth, my provider may not be able to help me modify or address issues with my location or environment that may interfere with the receipt of telehealth services. In the event of a technical failure, I understand that I should immediately contact my provider’s office or if it is an emergency, dial 911.
- E. I understand that laws protecting the confidentiality of my medical information also apply to telehealth and that ChristianaCare uses security protocols to help protect my privacy and ensure my confidential communications are sent only to the intended care team member(s).
- F. I understand that ChristianaCare will not record the video or audio of my telehealth visit without my consent at the time of the recording.
- G. I consent to have ChristianaCare obtain health information from me and provide health care services to me through telehealth communications when and where my provider or qualified member of my care team determines it is appropriate and necessary.
- H. I understand that my provider may collaborate with other professionals in the delivery of telehealth services, the same as an in-person visit. I understand that as with in-person visits, my provider may not be aware of all of collaborating professionals’ knowledge, experiences, and qualifications. I understand that under such circumstances my provider will use the same professional judgement and skill when working with other professionals as during an in-person visit.
- I. I understand that as with in-person visits, my provider may have other persons present with them to assist with the telehealth visit. My provider has informed me of all persons who will be present with them during my telehealth visit, the role of each person, and I consent to my provider sharing my health information in their presence.
- J. I understand that as with in-person visits, other individuals whom I choose to have present with me during my telehealth visit may hear my health information and I consent to my provider sharing my health information in their presence.
- K. I understand that I may refuse or stop participation in telehealth services and request alternate services, such as an in-person visit, at any time.

RELEASE FROM LIABILITY FOR VALUABLES

- A. I am responsible for loss or damage to personal property brought to a ChristianaCare facility, except for belongings placed in the hospital’s safe. I release ChristianaCare from all claims for lost, stolen or damaged property.
- B. If I am hospitalized, I agree that the maximum liability of the hospital for loss of any belongings placed in the hospital safe is limited to \$300 unless the hospital gives me a written receipt for a greater amount.

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Side 2 of 2

FINANCIAL RESPONSIBILITY

- A. I agree that I am financially responsible to ChristianaCare and other physician groups (e.g., Emergency Department, Anesthesiology, Pathology) for all charges for healthcare services provided to me during my visit.
- B. I understand I am responsible for charges which are not otherwise covered by government and/or commercial insurance coverage.
- C. I understand that ChristianaCare only recognizes commercial and/or government health care plans as insurance coverage and does not recognize cost sharing programs as insurance coverage. I understand that if I am not covered by a commercial or government healthcare benefit plan, I will be considered a self-pay patient. I understand I am responsible for charges regardless of my participation in a cost sharing program, information set forth on my membership card, and any restrictions set forth on a payment instrument by the cost sharing program.
- D. Upon getting my bill for services, if I do not meet my financial responsibility in a timely manner, I understand that I may be responsible for additional fees associated with the collection of any unpaid amount.

ASSIGNMENT OF BENEFITS

- A. I assign payment of all insurance or other benefits, under which I am entitled to coverage, to ChristianaCare, its healthcare contractors and related physician groups, as applicable, for healthcare services provided to me during my patient care visit.

MEDICARE ASSIGNMENT OF INSURANCE BENEFITS

- A. Where Medicare benefits apply, I confirm the information provided by me in applying for payment under Title XVIII of the Social Security Act is correct. I request payment of authorized Medicare benefits to ChristianaCare and its contracted services and physician groups for any services I receive. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits for related services.

PATIENT COMMUNICATIONS

- A. I consent to ChristianaCare communicating with me by phone, email, or text message to the telephone number and/or email address provided by me. I recognize and understand that there is a risk of an unintentional disclosure of information, including my protected health information, to a third party, if information is sent via email or text message. I also recognize and understand that my wireless carrier may charge me for text messaging.
- B. I consent and authorize ChristianaCare to use my email and telephone number for patient satisfaction surveys, delivery of healthcare information, visit follow up, advertisements, telemarketing purposes, billing matters and collections on an account.
- C. I consent and authorize ChristianaCare to use my telephone number and email to communicate with (i) an automatic telephone dialer and/or (ii) pre-recorded calls and/or (iii) text messages.
- D. I understand that I have a right to opt out of any and all patient communication methods mentioned above if contacted. I also understand that I am not required to provide my consent to all patient communication methods as a condition to receive healthcare services.
- E. This consent applies to all past, present and future communications from ChristianaCare until I revoke this consent in writing.
- F. I understand my Primary Care Physician will be notified of my admission to the hospital.

NOTIFICATION AND ACKNOWLEDGMENT OF FINANCIAL ASSISTANCE PROGRAM

I have been offered the opportunity to receive and review the "Financial Assistance Program Summary."

NOTICE OF PRIVACY PRACTICES

I have received a copy or have been given the opportunity to review the ChristianaCare "Notice of Privacy Practices."

CONSENT

I have read this document or it has been read to me and I understand my responsibility:

_____/_____/_____
 Patient/Representative Signature Relationship to Patient Date Time

(_____) _____
 Telephone Number Email Address

Interpretation: The information has been presented to the: patient representative decision maker in: _____
 The person who provided the interpretation is a qualified medical interpreter. Language

 Interpreter Name Agency and ID# (if applicable)

_____/_____/_____
 Witness Signature Print Name Date Time