CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

CONSENT FOR SERVICES

I, the undersigned Patient, Legal Guardian, Parent or Responsible Party on behalf of the Patient, consents for Atmore Community Hospital, its authorized representatives, and the patient's physicians to provide appropriate medical services including laboratory diagnostic tests, urine drug screen, blood drug screen, radiologic procedures, administration of medicines and other treatment as well as hospital care considered advisable or necessary by the patient's treating physicians. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as to the results of examination or treatment in this hospital. Physicians and their allied health professionals, including radiologists, pathologists, ER physicians and tele-specialists, visiting specialists are independent contractors with the patient and are not employees or agents of the hospital. They will bill separately for their services. I understand that the hospital is not responsible for nor does it assume any liability for the acts or omissions of any such independent contractors. Any proposed surgery has been discussed with my surgeon and I have been informed about the procedure, and its risks, benefits and alternatives. Tissues and specimens shall be disposed of according to hospital procedures, unless otherwise directed by the patient. Absent emergency or extraordinary circumstances, no medical or surgical procedures will be performed on a patient unless the patient has had the opportunity to confer with a physician or other health professional. The patient has the right to consent to or to refuse consent to any proposed procedure or plan of care. This includes tele-specialty care services that I understand are not located within the hospital. I understand and acknowledged that this facility participates in the education of nurses, physicians and other health care students and that these students may be involved in the care I receive. If I am pregnant, my physician may determine that it is necessary to take urine or blood samples to perform drug screens and I consent to both the taking of the samples and the performance of the screens. If a physician determines that a test for HIV infection is necessary, I consent to the performance of this test. Additionally, if in the course of my medical care, a healthcare worker is exposed to my blood, I give consent for a sample of my blood to be tested for certain communicable diseases (to include but not limited to HIV and Hepatitis B and C). I understand and acknowledge that I will be notified of the results. I further agree to release the Hospital, its employees, agents and assigns, and representatives from any and all liability arising out of the release of my records pursuant to the testing of blood for communicable diseases following a healthcare worker exposure.

MINORS AND AGE OF CONSENT IN ALABAMA

Where minors are involved, the following prevails. The parent's or guardian's consent is required if the patient is under the age of 16, UNLESS the patient is married, or has ever been married or is pregnant.

PHOTOGRAPHS/VIDEO RECORDINGS

If my physician deems necessary, I consent to medical images being made of me or my child/dependent. These photographs will become part of my medical record and treated as such with regard to release to other entities. Additionally, I consent to the use of a current picture inside the facility's electronic health record system to assist with appropriate patient identification. I understand that as a patient, I am not permitted to take photographs and/or video/audio recordings of other patients or workforce members without their written consent.

ACCESSING MEDICAL INFORMATION

I consent to the accessing of information to include paid claims data through my insurer and/or healthcare information from other hospitals or physicians that have treated me. This information may contain prior diagnoses, medications prescribed, physicians authorizing those prescriptions and treatment plans. This information will be used for the purpose of managing my care. I further consent and authorize the hospital and/or my physicians to obtain prescription information from any and all pharmacies providing prescription pharmaceuticals to me.

I understand that my medical records will be exchanged among my health care providers through a Health Information Exchange (HIE) and Watershed for continuity of care between healthcare encounters. Participating in the HIE is not a condition to receive healthcare. Atmore Community Hospital will follow state and federal laws, including HIPAA, when protecting the release of sensitive information. If you do not wish to share your information through an HIE, you must opt out by selecting the opt out choice and initialing below.

□ I give consent to sharing of healthcare information through an HIE or to practitioners involved in my care. _____ ***(INITIALS)***

□ I ***DO NOT*** give consent to sharing of healthcare information through an HIE or to practitioners involved in my care. _____ ***(INITIALS)***

PERSONAL PROPERTY AND VALUABLES

Personal property or valuables should be given to family members preferably for safe-keeping. However, the hospital maintains a safe for storage of money and valuables that patients must keep while hospitalized. I understand that Atmore Community Hospital is not responsible for any personal property or valuables, such as cell phones, money, credit cards, jewelry, luggage, clothing, dentures, eyeglasses, hearing aids, or other prosthetic devices that are not deposited in the hospital safe.

I _____ (do) or _____ (do not) request storage of my valuables in the hospital safe.

WEAPONS/CONTRABAND

I understand that the possession of weapons, including, but not limited to, firearms, knives and explosives of any nature are prohibited. I declare that I have none in my possession. I understand that narcotics, without proper prescription, other drug substances, narcotic appliances or apparatus, are illegal. I declare that I have none in my possession. In the event that a weapon or other contraband is found in my possession at any time during my stay in the Hospital, I hereby authorize its removal and consent to its destruction.

FINANCIAL AGREEMENT

The undersigned, in consideration of the services to be provided, jointly and severally, agrees to pay all charges for such services, including without limitation any deductibles and/or co-insurance amounts, and any other charges not covered or allowed by health insurance payors (and if applicable, any amounts not covered or allowed by Home Health Agencies, where patient is under a current episode of care). Hospital charges will be according to Hospital's Chargemaster. Physician charges will be according to their usual and customary rates. The undersigned agrees to pay the Financial

Obligation according to the hospital's or physician's credit terms and agrees that any payments may by or on behalf of the patient may be applied to any open account(s) the patient may have with the hospital, physician and/or their affiliated entities. If the undersigned fails to pay the Financial Obligation according to the hospital's or physician's credit terms and if the hospital or physician(s) files suit or takes other steps to collect any unpaid amount due, the undersigned agrees to pay the reasonable costs of collection activities, which costs may include a collection agency fee and/or a reasonable attorney's fee. Collection activities may include civil legal action, wage garnishment, tax refund garnishment and/or reporting to consumer credit reporting agencies. The undersigned agrees and consents that the undersigned may be contacted regarding the Financial Obligation by telephone at any telephone number associated with this account(s), including wireless telephone numbers, which could result in charges to you. The undersigned consents to be contacted by text messages, e-mails (using any email address associated with his account(s)), pre-recorded/artificial voice messages, and/or automatic dialing devices. If the undersigned is a family member or other representative of the patient, the undersigned is agreeing to all of the terms of this document on behalf of the patient.

ASSIGNMENT OF BENEFITS

The undersigned assigns payment of authorized insurance benefits including benefits payable to the policyholder or beneficiary, including without limitation Medicare, Medicaid and Tricare, directly to Atmore Community Hospital, or its authorized representatives. The undersigned further assigns to the physician(s) who provide services or his authorized representative(s) such benefits payable for physician's services. I agree that I will be responsible for charges not covered by this assignment. Furthermore, I hereby assign any state disability benefits to which I may be entitled.

MEDICARE/MEDICAID/TRICARE Applies □ YES □ NO
I certify that all information is correct which has been given to apply for payment under the Medicare, Medicaid, or TRICARE programs or other third-party payors. _____***(INITIALS)***

FINANCIAL ASSISTANCE

The hospital has a Financial Assistance Program for those patients who can't pay their financial obligations. If you can't pay, you should contact Atmore Community Hospital at 251-368-6399 to obtain a "Financial Assistance Application Form." These forms may also be obtained from any registration area or downloaded from our website at www.atmorehealth.org. If you are eligible for assistance, your financial obligation may be discounted in whole or in part. The hospital will advise you in writing of such eligibility, if any, and any remaining Financial Obligation. The hospital will assist you in setting up payment arrangements.

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned authorizes the hospital and the treating physicians, to furnish any medical and billing information (electronically, by fax, by mail or in person) about this account, including but not limited to the following:

(a) INSURANCE BILLING – Information requested by the insurance company, Medicare, Medicaid, TRICARE, other third-party payors or workers compensation carriers to support the claim submitted for payment of charges applicable to this account.

(b) MEDICAL NECESSITY AND APPROPRIATENESS OF SERVICES – Information requested by any utilization and/or peer review organization associated with the insurer(s) to evaluate the medical necessity and appropriateness of services of this account or to determine benefits for related services.

(c) This release may contain sensitive information about the treatment, diagnostic testing, or other medical information including psychiatric, alcohol, HIV or AIDS test results, drug abuse, and/or other confidential information. The recipients are prohibited from any re-disclosure of this information. The undersigned ahs the right to subsequently revoke this release. That revocation shall not pertain to information previously released, information requested in good faith by any health care facility or physician for facilitating continuing care and treatment is authorized.

(d) Additional information may be released to medical device manufacturers for tracking purposes.

(e) I understand that medical information may also be released to review organizations and if necessary any agencies that may be involved in post hospital care.

(f) I understand that all hospital deaths must be reported to the health department and organ procurement centers.

(g) I further understand that the Hospital may be required to release specific information as it pertains to communicable diseases or in any situations involving child/adult abuse/neglect.

I acknowledge that I have been given a copy of the Patient's Rights brochure.
_____ ***(INITIALS)***

I acknowledge that I have been offered a copy of the facility's Notice of Privacy Practices.
_____ ***(INITIALS)***

I acknowledge receipt of the "Important Message from Medicare" prior to or at the time of admission.
_____ ***(INITIALS)***

I acknowledge that I have read this consent and understand its purposes and content.

_____ _____
Patient (Legal Guardian, Parent or Responsible Party) *Relationship to Patient*

_____ _____
Policyholder/Guarantor, if different from Patient *Relationship to Patient*

_____ _____
Witness *Date/Time*

Revised October 1, 2025

8/12/21 *CHANGED FORMAT TO TWO COLUMNS ON THE PAGE, INSERTED NAME OF FACILITY UNDER ASSIGNMENT OF BENEFITS, CORRECTED SPACE AND LENGTH OF SIGNATURE LINES.*

5/3/22 *CHANGES TO BE EFFECTIVE 5/11/23*
REMOVED PARAGRAPH RELATED TO COVID PUBLIC HEALTH EMERGENCY.
ADDED "OR TO PRACTITIONERS INVOLVED IN MY CARE" TO ACCESSING MEDICAL INFORMATION SECTION.
ADDED WATERSHED TO HIE PARAGRAPH.

11/11/24 *CHANGES TO BE EFFECTIVE 11/18/24*
Added ""I acknowledge that I have been given a copy of the Patient's Rights brochure"

Removed entire Section dealing with Precertification:
~~PRECERTIFICATION~~
~~If your healthcare plan requires pre-certification for your service, it is ultimately the patient's responsibility to ensure that proper pre-certification is obtained. *IF YOUR CLAIM IS DENIED IN PART OR IN FULL, THE PATIENT WILL BE FINANCIALLY RESPONSIBLE.* _____ *(INITIAL)*~~

12/18/24 *CHANGES TO BE EFFECTIVE 1/6/25*

Add sentence regarding consenting to HIV testing as we no longer require a separate written HIV consent.

7/25/25 *CHANGES TO BE EFFECTIVE 10/1/25*

Age of minor consent changed from 14 to 16.