

In this document, “Patient” means the person receiving treatment. “**Patient Representative**” means any person acting on behalf of the Patient and signing as the Patient’s representative. Use of the word “I,” “you,” “your” or “me” may in context include both the Patient and the Patient Representative. With respect to financial obligations “I” or “me” may also, depending on the context, mean financial guarantor “Guarantor”.

“**Provider**” means the hospital and may include healthcare professionals on the hospital’s staff and/or hospital-based physicians, which include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, Anesthesiologists, Hospitalists, certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf.

1. **Legal Relationship between Hospital and Physicians and Advanced Practice Professionals.** I understand and acknowledge that the physicians and advanced practice professionals providing services to me in the hospital are independent contractors and not agents or employees of the hospital. “**Advanced Practice Professionals**” include, but are not limited to, my treating physicians/ surgeons, radiologists, pathologists, cardiologists, emergency physicians, anesthesiologists, contract physicians, hospital-based physicians, physician assistants, registered nurses, advanced practice registered nurses, certified nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical nurse specialists, doctors of nursing practice, radiology assistants, and anesthesiology assistants. Independent physicians and Advanced Practice Professionals are responsible for their own actions and the hospital shall not be liable for the acts or omissions of any such independent physicians and/or Advanced Practice Professionals.
2. **Consent to Treatment.** I consent to the procedures that may be performed during this hospitalization or during an outpatient episode of care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services rendered as ordered by the Provider. I consent to allowing residents and other individuals enrolled in a healthcare professional education program as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the Hospital, and that they will be supervised by instructors and/or hospital staff. I further consent to the hospital conducting blood-borne infectious disease testing, including but not limited to, testing for hepatitis, Acquired Immune Deficiency Syndrome (“**AIDS**”), and Human Immunodeficiency Virus (“**HIV**”), if a Provider orders such tests or if ordered by protocol. I understand that the potential side effects and complications of this testing are generally minor and are comparable to the routine collection of blood specimens, including discomfort from the needle stick and/or slight burning, bleeding or soreness at the puncture site. The results of this test will become part of my confidential medical record.
3. **Consent to Treatment Using Telemedicine.** I agree to being treated through telemedicine. With telemedicine, health care providers at different locations use electronic communications to share patients’ health information for diagnosis, therapy, follow-up care, and education.
I agree to forward my information to a third party as needed to receive care through telemedicine. I understand that existing confidentiality protections apply.
Telemedicine can improve access to care, but there are some risks. No results are guaranteed. These risks include but are not limited to:
 - technical problems with sending or receiving information
 - equipment failures that could cause information to be lost or delayed or cause delays in treatment.I understand that I can stop my consent to use telemedicine at any time. This will not affect my right to future treatment. This will not change my access to any program benefits.

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4. **Use of Biological Samples.** During your care at the facility, biological samples (such as blood and tissue samples) might be collected from you for purposes of your care. Sometimes, after your visit there might be excess or leftover biological samples no longer needed for your care. These samples are usually discarded. However, sometimes these samples might be used for research within our hospitals and occasionally made available to researchers at external groups such as universities, private companies, advocacy groups, and government agencies. The research can help answer questions about the causes of diseases, how to prevent them, or even how to treat them. Please note that for this kind of research, (i) there might be no practical way to inform you about the details or results of the research (even if it involves genetic research), (ii) generally, no results on tests performed on your samples during the research can be returned to you or entered into your health record, (iii) it is not likely that you will directly benefit from the research, and (iv) there are no plans to compensate or recognize you for use of your samples or any discoveries made during the research. When these samples are used in this manner, your privacy is safeguarded consistent with applicable federal and state privacy laws.
5. **Consent to Medication Not Yet FDA Approved and/or Medication Prepared/Repackaged by Outsourcing or Compounding Pharmacy.** As part of the services provided, you may be treated with a medication that has not received FDA approval. You may also receive a medication that has been prepared or repackaged by an outsourcing facility or compounding pharmacy. Certain medications for which there are no alternatives or which your physician recommends may be necessary for potentially life-saving treatment.
6. **Consent to Product Patient Assistance Programs Limited Power of Attorney (“LPOA”).** The Provider may be able to get free replacement or reimbursement for the cost of your drugs or medical products from the companies that make them through a patient assistance program sponsored by the companies that make your drugs or medical products and through charity foundations. If the hospital obtains replacement or reimbursement of cost of your drug or medical product from the manufacturer through such programs, the charge for the product or drug will be removed from your bill. Patient assistance programs require you to sign an application form in order for the hospital to obtain replacement or credits of certain drugs administered or devices implanted to qualifying patients. This LPOA allows the Provider and its claims processor to complete and sign your patient assistance program applications for you for so long as this program may be available to you.

I hereby appoint hospital and/or its claims processor, my attorney-in-fact for the sole and exclusive purpose of signing patient assistance program application forms on my behalf, so that hospital may attempt to obtain replacement or credits of certain drugs administered or devices implanted from the companies that make them. I understand that the final decision as to my acceptance in a patient assistance program lies with each pharmaceutical or medical device company and that submission by hospital provides no guarantee or assurance that any application will be approved. I will provide reasonable assistance and additional information and documentation as necessary to support each application. I further understand that: 1) signing this is voluntary; 2) some patient assistance programs may not accept applications via power of attorney and I agree not to hold hospital responsible for such denial; 3) my treatment, payment enrollment, or eligibility for benefits may not be conditioned upon signing this authorization; and 4) I may revoke this authorization at any time by notifying the Provider in writing at 68 Sweeten Creek Road, Asheville, NC 28803, however, such revocation will not affect any actions taken prior to facility receiving the revocation.

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This LPOA shall be in full force from the date signed and continue for so long as these programs may be available to you.

<input type="checkbox"/>	Yes, I consent to Product Patient Assistance Programs Limited Power of Attorney	<input type="checkbox"/>	No, I do not consent to Product Patient Assistance Programs Limited Power of Attorney
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7. **Consent to Photographs, and Video, Digital and Audio Recordings.** I consent to photographs, video, digital or audio recordings, and/or images of me being recorded for patient care, healthcare operations, security purposes and/or the hospital’s quality improvement and/or risk management activities. I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the facility without a specific written authorization from me or my legal representative unless otherwise required by law.
8. **Financial Agreement.** In consideration of the services to be rendered to Patient, Patient or Guarantor individually promises to pay the Patient’s account at the rates stated in the hospital’s price list (known as the “**Charge Master**”) effective on the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement to pay the Patient’s account. Some special items will be priced separately if there is no price listed on the Charge Master. An estimate of the anticipated charges for services to be provided to the Patient is available upon request from the hospital. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional goods and services.

The hospital will provide a medical screening examination as required to all Patients who are seeking medical services to determine if there is an emergency medical condition without regard to the Patient’s ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, Patient and Guarantor understand that if Patient does not qualify under the hospital’s charity care policy or other applicable policy, Patient or Guarantor is not relieved of his/her obligation to pay for these services.

If supplies and services are provided to Patient who has coverage through a governmental program or through certain private health insurance plans, the hospital may accept a discounted payment for those supplies and services. In this event any payment required from the Patient or Guarantor will be determined by the terms of the governmental program or private health insurance plan. If the Patient is uninsured and not covered by a governmental program, the Patient may be eligible to have his or her account discounted or forgiven under the hospital’s uninsured discount or charity care programs in effect at the time of treatment. I understand that I may request information about these programs from the hospital.

I also understand that, as a courtesy to me, the hospital may bill an insurance company offering coverage, but may not be obligated to do so. Regardless, I agree that, except where prohibited by law, the financial responsibility for the services rendered belongs to me, the Patient or Guarantor. I agree to pay for services that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, non-covered benefits due to policy limits or policy exclusions, or failure to comply with insurance plan requirements.

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9. **Professional services rendered by independent contractors and Advanced Practice Professionals are not part of the hospital bill.** I understand that physicians and other Advanced Practice Professionals may be called upon to provide care or services to me or on my behalf, but that I may not actually see, or be examined by all physicians or other Advanced Practice Professionals participating in my care; for example, I may not see physicians, including but not limited to, my treating physicians/ surgeons, radiologists, pathologists, cardiologists, emergency physicians, anesthesiologists, staff physicians, contract physicians, physician assistants and other Advanced Practice Professionals including those providing radiology, pathology, EKG interpretation, anesthesiology services or telemedicine. I understand that, in most instances, there will be a separate charge for professional services rendered by these providers and that I will receive a bill for these professional services that is separate from the bill for hospital services.
10. **Third Party Collection.** I acknowledge that the Providers may utilize the services of a third party Business Associate or affiliated entity as an extended business office (“**EBO Servicer**”) for medical account billing and servicing. During the time that the medical account is being serviced by the EBO Servicer, the account shall not be considered delinquent, past due or in default, and shall not be reported to a credit bureau or subject to collection legal proceedings. When the EBO Servicer’s efforts to obtain payment have been exhausted due to a number of factors (for e.g., Patient or Guarantor’s failure to pay or make a payment arrangement after insurance adjustments and payments have been credited, and/or the insurer’s denial of claim(s) or benefits is received), the EBO Servicer will send a final notice letter which will include the date that the medical account may be returned from the EBO Servicer to the Provider. Upon return to the Provider by the EBO Servicer, the Provider may place the account back with the EBO Servicer, or, at the option of the Provider, may determine the account to be delinquent, past due and in default. Once the medical account is determined to be delinquent it may be subject to late fees, interest as stated, referral to a collection agency for collection as a delinquent account, credit bureau reporting and enforcement by legal proceedings.

I also agree that if the Provider initiates collection efforts to recover amounts owed by me or my Guarantor, then, in addition to amounts incurred for the services rendered, Patient or Guarantor will pay, to the extent permitted by law: (a) any and all costs incurred by the Provider in pursuing collection, including, but not limited to, reasonable attorneys’ fees, and (b) any court costs or other costs of litigation incurred by the Provider.

11. **Assignment of Benefits.** Patient assigns all of his/her rights and benefits under existing policies of insurance providing coverage and payment for any and all expenses incurred as a result of services and treatment rendered by the Provider and authorizes direct payment to the Provider of any insurance benefits otherwise payable to or on behalf of Patient for the hospitalization or for outpatient services, including emergency services, if rendered. Patient understands that any payment received from these policies and/or plans will be applied to the amount that Patient or Guarantor has agreed to pay for services rendered during this admission and, that Provider will not retain benefits in excess of the amount owed to the Provider for the care and treatment rendered during the admission.

I understand that any health insurance policies under which I am covered may be in addition to other coverage or benefits or recovery to which I may be entitled, and that Provider, by initially accepting health insurance coverage, does not waive its rights to collect or accept, as payment in full, any payment made under different coverage or benefits or any other sources of payment that may or will cover expenses incurred for services and treatment.

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I hereby **irrevocably appoint** the Provider as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies for any and all benefits due me for the payment of charges associated with services and treatment rendered by the Provider. These authorized actions include administrative and non-administrative appeals of any denial or underpayment of benefits or coverage, litigation, other forms of dispute resolution in any forum or for any type of relief (including monetary and equitable) available under applicable laws, including without limitation all provisions of the Employee Retirement Income Security Act of 1974, on my behalf against any responsible payer, employer-sponsored medical benefit plans, third party liability carrier or, any other responsible third party (“**Responsible Party**”). I also transfer and assign to the Provider all of my rights to demand and receive the production of or access to any documents or information, including without limitation, copies of health plan documents and materials, from any entity or person to the fullest extent of my rights to do so under my health plan and applicable laws. The foregoing rights are assigned in their entirety without limitation and without reservation of any part or aspect thereof. This assignment shall not be construed as an obligation of the Providers to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

I agree to take all actions necessary to assist the Provider in collecting payment from any such Responsible Party should the Provider(s) elect to collect such payment, including allowing the Provider(s) to bring suit against the Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment acknowledge that it is my duty and responsibility to immediately pay any such payments to the Provider(s).

- 12. **Medicare Patient Certification and Assignment of Benefit.** I certify that any information I provide in applying for payment under Title XVIII (“**Medicare**”) or Title XIX (“**Medicaid**”) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to the hospital or hospital-based physician by the Medicare or Medicaid program.
- 13. **Private Room.** I understand and agree that I am (or Guarantor is) responsible for any additional charges associated with the request and/or use of a private room.
- 14. **Outpatient Medicare Patients.** Medicare does not provide coverage for “self-administered drugs” or drugs that you normally take on your own, with only a few limited exceptions. If you get self-administered drugs that aren’t covered by Medicare Part B, we may bill you for the drug. However, if you are enrolled in a Medicare Part D Drug Plan, these drugs may be covered in accordance with Medicare Part D Drug Plan enrollment materials. If you pay for these self-administered drugs, you can submit a claim to your Medicare Part D Drug Plan for a possible refund.
- 15. **Communications About My Healthcare.** I authorize my healthcare information to be disclosed for purposes of communicating results, findings, and care decisions to my family members and others I designate to be responsible for my care. I will provide those individuals with a password or other verification means specified by the hospital. I agree I may be contacted by the Provider or an agent of the Provider or an independent physician’s office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.
- 16. **Consent to Telephone Calls, Email or Text Message for Financial Communications.** I authorize the use of any email address or cellular telephone number I provide for receiving information relating to my financial obligations, including, but not limited to, payment reminders, delinquent notifications, instructions and, links to hospital Patient billing information. I agree that, in order for you, or your EBO Servicers and collection agents to service my account or to collect any amounts I

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may owe, I expressly agree and consent that you or your EBO Servicer and collection agents may contact me by telephone, on a recorded line, at any telephone number I have provided or you or your EBO Servicer and collection agents have obtained or, at any number forwarded or transferred from that number, regarding the hospitalization, the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving information relating to my financial obligations, including, but not limited to, payment reminders, delinquent notifications, instructions and links to hospital Patient billing information. I understand and acknowledge that my patient account number may appear in the email or text.

17. Consent to Email, Telephone Calls or Text Message for Healthcare Information, Discharge Instructions and Other Communications. If at any time I provide an email address or telephone number (whether wireless or a landline) to a Provider or EBO Servicer, I consent to receive messages from Providers and EBO Servicers regarding discharge instructions and other healthcare communications (including without limitation information about programs or services that might be of interest to me) at the email or telephone number (whether wireless or landline) that I have provided or you or your EBO Servicer have obtained or, at any text number forwarded or transferred from that number. These discharge instructions may include, but not be limited to: post-operative instructions, physician follow-up instructions, dietary information, and prescription information. The other healthcare communications may include, but are not limited to communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care, information about insurance coverage/eligibility, referrals, available treatment options and capabilities, health insurance plans and programs and services that might be of interest to me. I understand that providing my consent to receive such communications is not a condition of receiving services or care from Providers.

18. Release of Information. I consent to Providers using and disclosing healthcare information about me for purposes of treatment, payment and healthcare operations. I also consent to my health information being used and disclosed for public health and other purposes permitted by applicable law. Information covered by this consent includes, without limitation, history and physical records, emergency records, laboratory reports, operative reports, physician progress notes, nurse notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment records and discharge summaries. This consent specifically applies to genetic information and information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, substance abuse disorder and chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS. Uses and disclosures covered by this consent include, but are not limited to (i) exchanging healthcare information about me regarding a prior admission(s) and encounters to other healthcare providers and entities to coordinate Patient care or for case management purposes; (ii) releasing health care information about me to any person or entity liable for or involved in payment on the Patient's behalf including to verify coverage, address payment questions, or for any other purpose related to benefit payment; (iii) releasing healthcare information about me to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of my healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. Provider participates, or may in the future participate, in Health Information Exchanges (HIEs) or other organizations with healthcare providers, insurers, and/or other health care industry participants and their

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subcontractors in order for these individuals and entities to share health information for treatment, payment, health care operations and other purposes permitted by law, to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of patient health records and aggregating and comparing patient information for quality improvement purposes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS. Unless I notify Provider in writing that I desire to opt out of participation, I consent to health information about me being shared with participants in HIEs and other organizations as described above.

19. Other Acknowledgements.

Personal Valuables. I understand that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss of or damage to any money, jewelry, documents, furs, fur coats and fur garments, or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for the loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The liability of the hospital for loss of any personal property that is deposited with the hospital for safekeeping is limited to the greater of five hundred dollars (\$500.00) or the maximum required by law, unless a written receipt for a greater amount has been obtained from the hospital by the Patient. The hospital is not responsible for the loss or damage of cell phones, glasses or dentures or personal valuables unless they are placed in the hospital safe in accordance with the terms as stated above.

Weapons/Explosives/Drugs. I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings located anywhere on hospital property, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

Patient Visitation Rights. I understand that I have the right to receive the visitors whom I or my Patient Representative designates, without regard to my relationship to these visitors. I also have the right to withdraw or deny such consent at any time. I will not be denied visitation privileges on the basis of age, race, color, national origin, religion, gender, gender identity and gender expression, and sexual orientation or disability. All visitors I designate will enjoy full and equal visitation privileges that are no more restrictive than those that my immediate family members would enjoy. Further, I understand that the hospital may need to place clinically necessary or reasonable restrictions or limitations on my visitors to protect my health and safety in addition to the health and safety of other Patients. The hospital will clearly explain the reason for any restrictions or limitations if imposed. If I believe that my visitation rights have been violated, I or my representative has the right to utilize the hospital’s complaint resolution system.

Additional Provision for Admission of Minors/ Incapacitated Patient. If I am signing as legal guardian, I acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

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20. Patient Self Determination Act.

I have been furnished information regarding Advance Directives (such as healthcare or medical power of attorney and, living wills). Please check the box next to **one** of the following applicable statements:

<input type="checkbox"/>	I executed Advance Directive(s) and have been requested to supply a copy to the hospital	<input type="checkbox"/>	I have not executed Advance Directive(s), wish to execute one or more and have received information on how to execute an Advance Directive	<input type="checkbox"/>	I have not executed an Advance Directive and do not wish to execute one at this time
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21. **Notice of Privacy Practices.** I acknowledge that I have received the hospital’s Notice of Privacy Practices, which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other prescribed and permitted uses and disclosures. I understand that this information may be disclosed electronically by the Provider and/or the Provider’s business associates. I understand that I may contact the hospital Privacy Officer designated on the notice if I have a question or complaint.

Acknowledge: _____ **(Initial)**

22. **Acknowledgement of Notice of Patient Rights and Responsibilities.** I have been furnished with a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

Acknowledge: _____ **(Initial)**

23. **Acknowledgement:** I have been given the opportunity to read and ask questions about the information contained in this form, **specifically** including but not limited to the financial obligation’s provisions and assignment of benefit provisions, and I acknowledge that I either have no questions or that my questions have been answered to my satisfaction and that I have signed this document freely and without inducement other than the rendition of services by the Providers.

Acknowledge: _____ **(Initial)**

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Date:	I, the undersigned, as the Patient or Patient Representative, or, for a minor/incapacitated Patient, as the legal guardian or custodian, hereby certify I have read, and fully and completely understand this Conditions of Admission and Consent for Outpatient Care, and that I have signed this Conditions of Admission and authorization for medical treatment knowingly, freely, voluntarily and agree to be bound by its terms. I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any medical treatment or services. If insurance coverage is insufficient, denied altogether, or otherwise unavailable, the undersigned agrees to pay all charges not paid by the insurer.	
Time		
Patient/Patient Representative Signature: X _____ If you are not the Patient, please identify your Relationship to the Patient. (Circle or mark relationship(s) from list below): Spouse Parent Legal Guardian Neighbor/Friend Sibling Healthcare Power of Attorney Guarantor Other (please specify): _____ _____		Witness Signature: X _____ Additional Witness Signature: (required for Patients unable to sign without a representative or Patients who refuse to sign) X _____ HCA Corporate Standard COA-COS 07.30.21

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