KootenaiHealth

MY CONSENT TO MEDICAL CARE

Thank you for seeking care from Kootenai Health, including its hospitals, treatment centers and clinics (collectively "Kootenai"). This Consent and Acknowledgement Agreement authorizes Kootenai to provide you medical care, share your health information and receive payment for services provided. For a listing of all Kootenai locations, physicians and advanced practice professionals, please go to kh.org. Other than in the case of an emergency, you must sign this form prior to treatment.

GENERAL CONSENTS AND ACKNOWLEDGMENTS

1. I consent to and authorize the physicians and other health care providers who may be involved in my care to provide such diagnosis, care and treatment considered necessary for the care I am seeking or as may otherwise be advisable for my well-being. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, test, or surgery performed at Kootenai.

2. I understand that Kootenai's mission includes training healthcare providers. Because of this, physicians in training such as residents or fellows, medical students, nurses and other healthcare professionals in training may be involved in my care and treatment.

3. I understand that "Providers" include, but are not limited to, my treating and consulting physicians, emergency department physicians, radiologists, anesthesiologists, other specialists and advanced practice professionals whom these physicians employ or as otherwise may be involved in my care. Kootenai does not control or direct a Provider's care of his or her patients. Besides Providers employed by Kootenai Clinic or Kootenai Urgent Care, the Providers are independent medical practitioners who are not employees or agents of Kootenai, but who are permitted to use Kootenai hospital facilities for the care and treatment of their patients. I acknowledge that my decision to seek care at Kootenai is not based upon any understanding, representation or advertisement that these independent practitioners are employees or agents of Kootenai.

4. I understand that telehealth services may be part of my care at Kootenai if my Provider determines that such services are appropriate for my condition. Telehealth services are healthcare services delivered by a Provider at a different location from the patient via information technology and communication tools such as telephone and two-way audio/video. These services can involve both real-time, interactive communication between a patient and a Provider and the transmission of patient information for subsequent review by a Provider.

5. I agree that Kootenai and Providers may communicate with me in writing to any address I have provided, may communicate with me orally or by text message to any telephone number I have provided, and may communicate with me electronically to any email address I have provided.

6. I agree to provide accurate and complete information about my health history and my presenting complaint. I understand that I have the right, and the responsibility, to participate in my care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I understand that I have the right to decide whether to accept or refuse medical care. I understand that my health care providers will treat me with respect, and I agree to do the same for them to foster a safe environment for myself, staff, and other patients within Kootenai.

7. I understand that I am not allowed to take pictures or make video or audio recordings of other patients, Kootenai employees, Providers and trainees in Kootenai facilities. I understand that I may not take pictures or make video or audio recordings of my care unless specifically approved by my Kootenai health care team according to Kootenai policy.

8. I understand that Kootenai facilities are places of safety and healing and therefore weapons, illegal drugs, alcohol, tobacco and tobacco substitutes are not allowed and I will not possess or use them while receiving care.

9. I understand that Kootenai will not be responsible for the loss, destruction or theft of any personal property that I bring with me to Kootenai. I take full responsibility — and release Kootenai from responsibility and liability — for my personal property.

HEALTH INFORMATION CONSENTS AND ACKNOWLEDGMENTS

10. I understand that Kootenai will use and disclose my health information for the purposes of treatment, payment, and healthcare operations. I understand, acknowledge and consent to the release of my personal health

information for the purposes outlined in this section, as described in the Notice of Privacy Practices pamphlet which has been offered to me, and as may otherwise be permitted by law.

11. I understand that Kootenai will record medical and other information related to my treatment in paper, electronic and other formats and that such information will be used in the course of my treatment, for payment purposes and to support healthcare operations. This includes photographic, video and electronic monitoring and recording methods. I give consent for my treating physicians and other health care providers to exchange information with other health care professionals and providers (for example physicians, consultants, hospitals, nursing homes, home health agencies and pharmacies) about my prior and current health conditions to facilitate treatment, or to facilitate discharge planning.

12. As applicable, I specifically consent to the release by Kootenai of any and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to: 1) my treating physicians and other healthcare providers, and; 2) any private health insurance plan, Medicare, Medicaid, other governmental insurance program or other third-party payer that I identify to obtain payment for the treatment and services provided to me.

13. During a hospital stay, unless I request otherwise, Kootenai will provide my room location and telephone number to visitors and callers if requested.

FINANCIAL CONSENTS AND ACKNOWLEDGMENTS

14. In consideration of the services provided to me by Kootenai, I agree to pay Kootenai and any Providers involved in my care for all services and supplies provided to me. If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover my treatment, I authorize Kootenai and Providers to bill any such insurer for all charges incurred by me in connection with my diagnosis, care and treatment. I certify that I have provided accurate information regarding my insurance coverage and eligibility to the best of my knowledge. I understand that my insurance coverage may require that some amount of the bill be my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by my health insurance, Medicare, Medicaid or any other programs for which I am eligible. I understand that certain payments may be required at the time of, or in advance of, services being provided. I also understand I may be billed for any charges not paid by my insurer, and I will be responsible for paying them. I understand and acknowledge that:

- I am responsible for notification to my insurance company to obtain authorization before service is rendered, and if I do not pre-certify for such services, my benefits may be reduced or lost, but I will still be responsible for paying Kootenai for the services. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.

- I will receive separate bills for the services provided to me by the employed and independent Providers involved in my care. The independent Providers involved in my care may not be participating providers in my insurance plan or network and I may have greater financial responsibility for their services if they are not under contract with my health plan.

- If I elect to pay for medical treatment in cash, in full before services are provided, I can request that my health insurance, in any form, not be billed for that service or be notified that the service was provided. If I have not paid for my treatment in cash and in full before or at the time of services, I understand and acknowledge that Kootenai may disclose my personal health information to an identified insurer with whom I may have coverage for the purposes of obtaining payment.

I hereby assign to Kootenai, and any independent professionals involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which benefits may be available to pay for the services provided to me, and authorize payment for such service to be made directly to Kootenai, or independent professionals.

15. I consent to receive written, electronic, text messages, phone calls and prerecorded messages using automated technology from Kootenai and/or any Provider or Provider groups associated with my care, and any of their agents, representatives or business associates, including their billing service providers and any potential debt collectors, for the purposes of servicing my account, collecting amounts due, and/or communications related to patient satisfaction

at the phone numbers (landline or cellular) that I have provided Kootenai or may provide in the future. I understand that I have the option to "opt out" of receiving such emails or text messages, which I may exercise at any time by following the opt out option contained in the message, or notifying Kootenai in writing to discontinue such communications using those pathways. I understand that opt out processes may take up to ten (10) business days to go into effect. Unless I have opted out, communications may continue after the expiration of this consent form.

16. If I do not pay for treatment provided or default on a payment, I acknowledge and agree that Kootenai is entitled to recover the full amount of the debt owed for medical services and is entitled to the right of recovery of all collection expenses, including litigation or arbitration costs, and reasonable attorney's fees incurred for the purpose of securing payment, as allowed by Idaho law.

17. As a part of our strong commitment to ensuring access to medical care, Kootenai offers financial assistance for medically necessary services. I understand that I may still qualify for financial assistance even if I have medical insurance. Eligibility is determined based on federal poverty guidelines, family size, and other criteria. I may apply for potential financial assistance prior to service, at the time of service, or at any point in the billing process up to the resolution of the account.

COMMUNICATION PREFERENCES – KOOTENAI CLINIC AND KOOTENAI URGENT CARE ONLY

My preferred method of communication is (check one):

Cellular phone ☐ Home phone ☐ Work phone ☐

Medical information and test results may be left on my answering machine/voice mail (check one):

Yes ☐ No ☐

Medical information and test results may be sent to me via text message to my cellular phone (check one):

Yes ☐ No ☐

I agree to allow KOOTENAI to contact the following family or friends as necessary to provide appointment reminders, to obtain payment and to receive information of my location and general condition. I understand that Kootenai may contact these identified individuals for these purposes unless I later instruct Kootenai otherwise (check one):

Yes ☐ No ☐ If yes, please provide the following –

Name	Address	Phone	Relationship

PRESENTATION OF MY CONSENT TO MEDICAL CARE

I acknowledge that I will be presented with this Consent and Acknowledgement Agreement once every year, and it will apply to all patient encounters within Kootenai that happen during that year.

I HAVE READ, UNDERSTOOD AND FULLY AGREE TO each of the above statements and sign below as my free and voluntary act. I ALSO ACKNOWLEDGE that I have been offered Kootenai's Patient Guide containing information on patient rights, privacy practices, and financial matters.

Patient (or Authorized Person) Signature	Printed Name (and Relationship)	Date

Witness (printed name and signature)	Date

ADMCON