

I request services and care be furnished to me by any CCM Health entity or affiliate:

1. GENERAL CONSENT FOR TREATMENT

I agree to the performance of such procedures and treatments that the attending/consulting physician deem necessary.

2. RELEASE OF HEALTH INFORMATION

Health Information includes transfer records, medical records, photos, financial documentation, and other documentation. I authorize CCM Health to release my information as follows:

- A. To all third-party insurance carriers, health service plans, health maintenance organizations, or third-party administrators (my insurance company). This release is necessary to determine payment of my CCM Health bill, payment of claims, and/or fraud investigation.
- B. For quality of care review studies.
- C. To other CCM Health facilities for patient care and billing purposes.
- D. To other health care providers for patient care and billing purposes.
- E. For research. Most clinical research using my information requires CCM Health to obtain a separate consent. CCM Health will not obtain separate consent if: (a) the researcher certifies the information is only for preparing the project; they will maintain the confidentiality of the information; and will not remove any information from CCM Health or (b) an Institutional Review Board (IRB), determines in advance that use or disclosure of my health information meets specific criteria required by law. If I do not wish to have my information shared for research in these two instances, I may opt out by initialing here: _____
- F. To callers or visitors seeking to visit or speak with me during this hospitalization or visit. This may include clergy.
- G. To independent contractors or technicians on an incidental and limited release in order to repair information systems. These parties sign confidentiality agreement.
- H. I understand that my medical record is part of the CentraCare Electronic Medical Record, an integrated Electronic Medical Record System. CentraCare and non-CentraCare organizations may access this secured system to provide improved patient care, patient safety, and coordinated care. A list of these affiliates will be provided upon request.
- I. I understand certain circumstances may require disclosure of information to organizations such as health departments or the Centers for Disease Control and Prevention. This may include cases of HIV, tuberculosis, viral meningitis, and other diseases.

3. VIDEO AND AUDIO RECORDING

I understand that my stay at CCM Health will be subject to video and audio recording for the safety of patients, employees, and visitors.

4. INSURANCE BENEFITS, GUARANTEE OF ACCOUNT, AND RELATED INFORMATION

- A. I personally guarantee payment of any CCM Health bill, including services which are not paid by insurance, government programs, or other third-party sources.
- B. I personally guarantee payment of any charges resulting from any and all health care services. This includes charges, which for any reason, are not paid in whole or in part by insurance, government programs, or other third-party sources. Similarly, I understand CCM Health is not bound by language contained on my medical benefits card or any representation made accompanying an insurer or other third-party payors' payment, purporting to limit my obligation to pay or CCM Health's right to payment in

full for services. I agree and acknowledge that CCM Health does not agree to any reduction or waiver of any charges for any reason except pursuant to CCM Health policy or the acceptance of a participating provider's contract with an insurer, government program, or other third-party payor.

- C. I request payment for Medicare, Medicaid, and/or health insurance benefits which I may be entitled, including physician services. I authorize insurance, Medicare, Medicaid, or other funds that I or the patient, if the patient is a minor, may be entitled to, paid directly to CCM Health.
- D. My insurance company may share my past, present, and future health or account records with CCM Health or other providers for the purpose of managing, coordinating, or improving my care.

5. EMAIL AND OTHER ELECTRONIC METHOD CONTACT

When you provide CCM Health an email or telephone number, you consent to receiving communication, including but not limited to, prerecorded or artificial calls, text messages, and calls made by an automatic dialing system from CCM Health or an agent regarding my care. Contact may incur access fees from the cellular provider.

6. CONSENT TO TREATMENT AND EVALUATION OF MINOR PATIENT

I consent to CCM Health providers, professionals, and care-coordinators contacting the minor patient for re-evaluation and treatment related to the Patient Health Questionnaire (PHQ-9) for a period of one year from the date of my signature. This contact may occur via phone, text-message, artificial voice-messaging, email, or in-person.

7. APPLICABILITY TO OTHER PROVIDERS

Other providers may furnish me services while at CCM Health including providers that furnish information and services for billing and patient care, by electronic database or otherwise. I acknowledge that the above consents apply to these providers.

8. TELEHEALTH

I understand that telemedicine is the use of electronic information and communication technologies by a provider to deliver services to me when the provider is located at a different site; and hereby consent to CCM Health providing health care services to me via telemedicine.

9. PROPERTY

I understand CCM Health is not responsible for any loss of cash, jewelry, or other personal property which I choose to keep in my possession.

10. PATIENT BILL OF RIGHTS

A copy of the Minnesota Patient Bill of Rights has been made available to me.

DISCLOSURE OF PHYSICIAN COVERAGE: CCM HEALTH is a critical access hospital providing 24-hour service to our community, complying with Medicare's Critical Access Hospital regulations. We are staffed with highly trained and qualified personnel. We do not have a physician in the building 24-hrs a day/7 days a week. During these times nurses or physician assistants assess and monitor patients and call in physicians when needed. Our scheduling system ensures a physician is immediately available when a patient needs emergency care. We are dedicated to providing high-quality care, close to home.

RELATIONSHIP: Self Legal Guardian Other (Emergency Department only)

SIGNATURE OF PATIENT/ AUTHORIZED REPRESENTATIVE

REASON PATIENT DID NOT SIGN:

PATIENT NAME:

PATIENT MRN:

PATIENT DOB:

DATE: