31194

# CONSENT AND AUTHORIZATION

UF UNIVERSITY of FLORIDA

MRN: | | | | | | | | | | |

PATIENT NAME: _____ VISIT DATE: _____

**SECTION A: NOTICE OF LIMITED LIABILITY**

The care provided by the University of Florida and Shands Teaching Hospital and Clinics, Inc., is subject to the provisions of s. 768.28, Florida Statutes, which limits recovery for negligent acts and omissions as set forth therein.

**SECTION B: CONSENT AND AUTHORIZATION**

I. **Authorization for Routine Diagnostic Procedure and Medical Treatment:** I hereby consent to such diagnostic procedures, hospital care, and medical treatment which in the judgment of my health care provider may be considered necessary or advisable while a patient at a University of Florida Physicians facility. I recognize that the University of Florida Physicians are employees of a health care teaching and research institution, and that my treatment and care will be observed and in some instances aided by students under appropriate supervision. I understand that my physician may access my medical information from a variety of sources, including information about my medication use that comes from proprietary sources. I consent to the University of Florida Physicians video-taping and taking photographs of me in the course of and related to my treatment and to their use of such videos, photographs and my medical data for educational purposes.

II. **Authorization to Use/Retain/Preserve Tissue:** I hereby authorize the University of Florida Physicians to retain, preserve and use for scientific, educational or research purpose, or dispose of as they might deem fit, any specimens or tissues taken from my body during hospital or clinic visits. If applicable, this authorization is also given on behalf of my unborn child during this period of treatment and/or examination.

III. **Assignment of Benefits:** I hereby assign to the University of Florida Physicians payment from all third party payors* with whom I have coverage or from whom benefits are or may become payable to me, for the charges of hospital and health care services I receive for, related to, or connected with this admission or treatment (past, present, or future). I agree to be personally responsible for payment of any hospital or health care services that are not covered by my third party payors*, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments.

IV. **Release of Medical Information by the University of Florida Physicians:** By signing in the space below as Patient/Guardian, I hereby authorize the University of Florida Physicians providing services during my outpatient clinical care, to release information from and/or copies of my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests), and other information as may be required for my medical care and to secure payment for charges incurred by me or on my behalf, to: any University of Florida Physicians facility or affiliated provider, the Tumor Registry, my physician, to my referring physician, the Guarantor on my accounts, insurance companies for which I have assigned benefits for my treatment and care, or to any sponsors that the University of Florida Physicians may later obtain to contribute payment for my treatment and care. I also authorize release of any information to any and all regulatory and/or accrediting organizations as necessary to the outpatient clinics to maintain its licensure and accredited status. In addition, I authorize release of any information to county, state or federal public health agencies, as required by law. I further authorize the Department of Child and Family Services and/or the Social Security Administration to release any confidential case information to my application for government assistance, which is requested by the University of Florida Physicians.

V. **Risk Management and Dispute Resolution:** I agree that my patient information (including, but not limited to, my medical records, billing information, and information I disclose to a health care provider in the course of my care and treatment) may at any time be used by and disclosed to employees, officers, agents, and legal representatives of Shands or the University of Florida, or both, for purposes of risk management, and formal and informal dispute resolution processes (including, but not limited to, litigation and mediation) involving one or both entities.

VI. **Agreement to Mediate:** In accepting care at a University of Florida facility, I agree that before I file any lawsuit against the University or any of its facilities, employees or agents, and/or the University of Florida Board of Trustees, arising out of the care provided to me by physicians, nurses, and other healthcare providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party person who has been certified to be a mediator tries to help settle claims. The University will pay the cost of the mediator. I further agree that any mediation must take place in the State of Florida and in the county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

VII. **Guarantor Agreement:** By signing in the space below as Patient/Guardian or Guarantor, or as Patient.s/Guardians Spouse or Guarantor.s Spouse, I hereby agree that all charges connected with the treatment, not covered by any insurance, program, sponsorship or other third party coverage I may have, are due and payable by me at the time of the visit or discontinuation of treatment. If the insurance information I have provided is not active at the time of service or if the services provided are not covered by my insurance company, I will be responsible for any balance due at the time of service. The charges I agree to pay are University.s set fees, as modified by any applicable contract University may have with an insurer, which are available for inspection upon request and incorporated herein by reference. I understand that billing statements will be sent to the patient for whom the services have been rendered, but as guarantor, I am responsible for payment. I hereby acknowledge that, unless the University of Florida Physicians and my insurance company or third party carrier have agreed that I will not be billed, if the University of Florida Physicians has agreed to bill my insurance or other third party carrier it has agreed to do so as a courtesy and that the University of Florida Physicians has the right to demand payment in full from me at any time prior to full payment from any insurance carrier. If an overdue account is referred by collections, I agree to pay the attorney.s fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the outpatient clinic charges I have agreed to pay.

VIII. **Agreement to Pay for Professional Component of Pathology Services:** When a specimen of my blood, urine, stool, or similar material is tested, the testing will be performed under the supervision of the pathologist who directs the laboratory. The pathologist may not perform the test or personally review its results. However, the pathologist is responsible for supervising the laboratory. I will receive a bill from the pathologist for these supervisory services for each test even if the pathologist did not personally perform the test or review its results. By signing this document, I agree to be responsible for the pathologist.s bill to the extent that payment is not provided by my Third Party Payor.

*Third Party Payors include, but are not limited to, coverage available from: Medicare, Medicaid, Tri-care, or governmental programs; health, accident, automobile, or other insurance; worker.s compensation; HMO (commercial, Medicaid, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

**Patient/Guardian**_____ **Patient/Guardian's Spouse**_____

**Insured**_____ **Insured**_____
(If other than patient) (If other than patient)

**Guarantor**_____ **Guarantor's Spouse**_____
(If other than patient/guardian) (If other than patient/guardian's spouse)

**Witness**_____ **Date**_____

COPIES OF THIS STATEMENT SHALL BE AS VALID AS THE ORIGINAL/ORIGINAL SIGNATURES ON FILE WITH THE UNIVERSITY OF FLORIDA PHYSICIANS

Form #309/UFP/Updated 7/1/2011 DXM



Send Form to Imaging-PO BOX 100354