

**Excelsior Springs Hospital
General Consent to Treat**

Consent for Treatment: I consent to and authorize Excelsior Springs Hospital and its entities and affiliates to provide healthcare services including examinations, diagnostic and laboratory procedures, anesthesia, medical treatment, or monitoring that are deemed advisable or necessary in the diagnosis and treatment. I understand the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may involve risk or injury or even death. I acknowledge no guarantees have been made as to the result of examination or treatment in this hospital.

Professional Care: I understand I am under the professional care of an attending physician(s) who arranges for services. I understand that health care personnel in training, whose presence is under the supervision of trained professionals and agree they may be present during my patient care as part of their education.

Clinical Photography and Video/Audio Technology: I authorize Excelsior Springs Hospital and my physicians to take photographs or other images of me or parts of my body to be used in medical evaluations, education, or research. I authorize the use of video and audio technology to monitor, assess and interact with me while under the care of Excelsior Springs Hospital which can involve the delivery of health care by a provider who is at a different location. I am not allowed to take photographs that include faculty, staff, students, or employees without verbal consent. At no time may these photographs be posted on social media or copied for publication.

Patient identification photos may also be taken to ensure patient identity and facilitate medical care. Photos may be updated when my physical condition changes.

Artificial Intelligence (AI) Use in Care: I understand Excelsior Springs Hospital may use HIPAA secure, approved AI tools to assist healthcare professionals in reviewing medical information, supporting clinical decisions, documentation, and other administrative functions. These tools are intended to enhance, not replace, the professional judgement of qualified healthcare providers. All final decisions regarding my care will be made by licensed professionals.

Radiation Exposure: I am aware some imaging tests and procedures beneficial to my care may expose me to radiation. I understand my radiation exposure will be kept as low as possible. Any specific risk associated with the test or procedure, or radiation will be explained to me by my provider. I understand I have the right to refuse the test or procedure.

Telemedicine: Medical treatment may include the use of telemedicine, digital imaging and virtual care by your provider.

Occupational Exposure: Should a healthcare worker be exposed to my blood, body fluids, or tissue during my care, I hereby give consent to testing for the presence of Hepatitis B virus surface antigens, Hepatitis C antibody and Human Immunodeficiency Virus antibodies. My healthcare provider will convey the results to me. I understand law permits this testing and should such testing occur, I will not be billed for it.

Release of Information: I understand the confidentiality of medical records and information will be protected to the full extent of the law and will only be disclosed with my prior written authorization, unless the disclosure is otherwise permitted or required by applicable law. Please refer to the Excelsior Springs Privacy Practices which governs release of information.

I understand my medical records will be exchanged among my health care providers through a Health Information Exchange (HIE) and or Health Registries. Participating in these is not a condition to receive healthcare. Excelsior Springs Hospital will follow state and federal laws, including HIPAA, when protecting the release of sensitive information. I acknowledge I may request to opt out of the HIE and / or Health Registries.

Implanted medical devices: I understand Excelsior Springs Hospital, when required, will release my social security number to the manufacturer of any medical device implanted or prescribed to me so I may be notified in the event of a recall.

Behavior Expectation: I agree it is my responsibility to treat other patients, visitors, and staff with respect. I understand disrespectful behaviors will not be tolerated and may lead to my discharge.

Service Terms:

Assignment of Insurance Benefits: I assign all my interest and rights to all insurance benefits, otherwise payable to me from any insurance policy covering my period of hospitalization or outpatient treatment, issued in my name or on my behalf to Excelsior Springs Hospital. I authorize my insurance carrier to pay the applicable policy benefits directly to the hospital, or members of its medical staff for reimbursement of all professional services rendered to me during my hospitalization or outpatient treatment.

Personal Financial Responsibility and Cooperation: I may be responsible for fees to Excelsior Springs Hospital not paid by any third party on my behalf. I understand I will be charged in accordance with the regular rates and terms of the facility. I understand my account may be eligible to have my account discounted under the hospital's financial assistance policy in effect at the time of treatment. I understand if

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I or my Guarantor do not qualify for the hospital's financial assistance policy, we are not relieved of the obligation to pay for services rendered. I have been informed and agree to cooperate with Excelsior Springs Hospital in submitting my application for any governmentally subsidized program or internal

financial assistance that may provide partial or total reimbursement for certain services. If such funds are available, I hereby authorize funds be paid directly to Excelsior Springs Hospital on my behalf for my account.

Statement Applicable to Medicare/Medicaid Patients: 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 be made on behalf to the hospital or the hospital-based physician by Medicare or Medicaid program, I have been informed some services may not be covered by my health insurance benefit plan or, if applicable, by Medicare. Medicare will only pay for services that they determine to be "reasonable and necessary" under section 1862 (a)(1) of the Medicare law. If Medicare determines a particular service, otherwise covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that specific service and patient may be financially responsible.

Third Party Billing and Collection: I acknowledge Excelsior Springs Hospital may utilize the services of a third party for medical account billing and collection. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal authorized rate.

Communications Consent: By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from Excelsior Springs Hospital and its agents, including those that may be made using an automatic or computer-assisted telephone dialing system, text messaging, and/or artificial or pre-recorded voice message. These parties may use this information to contact me for any purpose related to my care at Excelsior Springs Hospital, including but not limited to, appointments, health care reminders, wellness checkups, pre-registration, and pre-operative instructions. I understand that depending on my phone plan I could be charged for these calls or text messages.

General Terms:

Personal Belongings: I am informed and agree that I am responsible for all personal belongings brought to Excelsior Springs Hospital and its affiliates. I have been informed that I should send all personal belongings home for safe keeping while under care, and weapons and illegal substances are not allowed in the hospital or clinics.

Tobacco Free Campus: I understand Excelsior Springs Hospital and off-site locations are tobacco-free. I acknowledge I cannot smoke, vape, or use tobacco products of any kind anywhere on these campuses, including the parking lot, or physical grounds of these facilities.

Notice of Privacy Practices and Patient Rights: I acknowledge I have been offered a copy of the Notice of Privacy Practices describing my right to privacy and how the hospital may use and disclose my protected health information and I have the right to ask Excelsior Springs Hospital to request certain restrictions as to how my information will be used or disclosed. I acknowledge I have been offered and provided access to Excelsior Springs Patient Rights and Responsibilities.

Hospital Directory: I acknowledge, if admitted, my room number will be given out unless I notify my care team otherwise.

My signature below acknowledges I have read and understand this document and I am authorized to sign.

Signature of Patient/Legal Representative

Date and Time (include AM/PM)

Printed name of Patient/Legal Representative

Relationship to Patient
(if signed by Legal Representative)

Reason Patient Cannot Sign *(if signed by Legal Representative)*

Witness Printed Name and Signature

Date and Time (include AM/PM)

