Part I

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"**. **"System"** means Southern Monterey County Memorial Hospital DBA Mee Memorial Healthcare System and may include healthcare professionals on the hospital's staff and/or hospital-based physicians contracted with the hospital. These may include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, Anesthesiologists, Hospitalists, and certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf.

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.

1. **Legal Relationship between Hospital and Physicians.** All physicians and surgeons providing services to me, including the radiologist, pathologist, emergency physician, anesthesiologist and others, are not employees, representatives or agents of the Hospital. They have been granted the privilege of using the Hospital for the care and treatment of their patients, but they are not employees, representatives or agents of the Hospital. They are independent practitioners.

   I understand that I am under the care and supervision of my attending physician. The hospital and its nursing staff are responsible for carrying out my physician's instructions. My physician or surgeon is responsible for obtaining my informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services provided to me under my physician's general and special instructions.

   Patient Initials: ___________________________

2. **Consent to Treatment**. I consent to the procedures which may be performed during this hospitalization or during an outpatient episode of care, including, but not limited to, emergency treatment or services, laboratory procedures, x-ray examinations, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services provided to me under the general and special instructions of the provider. I consent to allowing students 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 these students 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 physician 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 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. **Interpreter Services.** Sign language and oral interpreters, TTYs/TDDs, assistive listening devised and/or other auxiliary aids and services are available free of charge to patients and companions who need them for effective communication. For assistance, please contact any facility staff member.

4. **Consent to Photographs, Videotapes and Audio Recordings.** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for treatment and/or hospital health care operations and/or 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 understand that the images from such photography may be used for my treatment or hospital health care operations. 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.

Signature:____

Patient/Patient Representative **Date / Time**

PLACE LABEL HERE

1. **Telehealth Services.** George L. Mee Memorial Hospital ("Hospital") allows patients to attend appointments and consult with providers via online videoconferencing. These services are referred to as "Telehealth" and are offered through WebRTC.

2. **Basics of Telehealth**
   a. Telehealth is the use of electronic communications to provide and deliver health care services over large and small distances and includes a variety of health care and health promotion activities, including education, advice, reminders, consultation, treatment, interventions, and monitoring of interventions.
   b. Telehealth includes a real-time interaction between a patient and provider through live videoconferencing.
   c. Your personal health information will be shared with the provider. This personal health information may include your medical and health history, the information you provide to the provider and live two-way audio and video.

3. **Benefits of Telehealth.** Telehealth provides many potential benefits, including increased access to healthcare and specialists and the convenience of accessing providers from your own computer.

4. **Risks of Telehealth.** All healthcare services include potential risks, and this is no different in Telehealth. The potential risks associated with Telehealth include, but are not limited to, the following:
   a. Reliability or Integrity of Technology. There is a potential that the information transmitted via videoconference may be insufficient to allow for the provider to make appropriate medical decisions regarding your treatment. There may also be delays in your treatment or evaluation due to technological or equipment failures.
   b. Limited Access to Information. The provider may not have access to your full medical record. This may result in adverse drug interactions, allergic reactions, or other judgment errors due to a lack of information.
   c. Security of Computer Systems. We have taken steps to safeguard our network and software in order to protect your information, but in rare circumstances, these safeguards may fail, causing a breach of your personal and health information.

5. **Alternatives to Telehealth.** Telehealth services are meant to supplement, and not replace, in-person consultations with your healthcare providers. You should continue to maintain a relationship with your primary care physician. You should seek emergency help or follow-up care when recommended by a Provider or when otherwise needed. A Telehealth provider may refer you to an in-person consultation if they feel this is necessary.

6. **Privacy of Telehealth.** The Hospital is required to comply with all federal and state health care privacy and security laws regarding the security and safeguarding of your personal health information.

Information governing our use of health and other personal information is provided in our HIPAA Notice of Privacy Practices, which is available at: https://meememorial.com/for-patients/patient-rights/ .

7. **Use of Telehealth by Minors.** Informed consent is required to access Telehealth from the Hospital. Children under the age of 18 or who are not emancipated must have the affirmative informed consent of their parent or legal guardian in order to use the Hospital's Telehealth services.

8. **Consent to Use Telehealth.** By agreeing to use the Hospital's Telehealth services, you acknowledge and agree to the following:
   a. You have read and understood this Informed Consent to Receive Telehealth Services.
   b. You have been duly informed by the Hospital of the nature, risks, and possible complications and consequences, and available alternative methods of treatment to Telehealth.
   c. You understand that the laws that protect the privacy and the confidentiality of your protected health information also apply to Telehealth and that you have received the Hospital's Notice of Privacy Practices.
   d. You understand that your provider may determine that Telehealth services are inappropriate for your needs and may decide not to provide services through videoconferencing.
   e. You know that the practice of medicine and Telehealth is not an exact science, and you have neither asked for nor received any guarantees or promises as to the results that will be obtained.
   f. You understand that you can withhold or withdraw this consent at any time.
   g. You represent that you have the legal capacity and authority to provide this consent for yourself and/or the minor for whom you are consenting under applicable federal and state laws, including laws relating to the age of majority and/or parental guardian consent.
   h. You understand and acknowledge that there is no guarantee that you will be treated by a provider if, for example, the provider determines that your condition cannot be properly treated through Telehealth.

Patient name *(please print)*:____ Date:_________________

Patient signature:____

Parent/Guardian signature:____

PLACE LABEL HERE

Part II

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"**. **"System"** means Southern Monterey County Memorial Hospital DBA Mee Memorial Healthcare System and may include healthcare professionals on the hospital's staff and/or hospital-based physicians contracted with the hospital. These may include but are not limited to: Emergency Department Physicians, Pathologists, Radiologists, Anesthesiologists, Hospitalists, and certain other licensed independent practitioners and any authorized agents, contractors, affiliates, successors or assignees acting on their behalf.

1. **Nursing Care.** This Hospital provides only general nursing care and care ordered by the physician(s). If I want a private duty nurse, I agree to make such arrangements. The Hospital is not responsible for failure to provide a private duty nurse and is hereby released from any and all liability arising from the fact that the hospital does not provide this additional care.

2. **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.

   Professional services rendered by independent contractors may be billed to the Patient separately. I understand that physicians or other health care 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 health care professionals participating in my care: for example, I may not see physicians providing radiology, pathology, EKG interpretation and anesthesiology services. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I may receive a bill for these professional services that is separate from the bill for hospital services.

   If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. However, Patient and Guarantor understand that if the Patient does not qualify under the hospital's charity care policy or other applicable policy, the Patient or Guarantor is not relieved of his/her obligation to pay for these services.

   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 service(s) that are not covered and covered charges not paid in full by insurance coverage including, but not limited to, coinsurance, deductibles, due to policy limits or exclusions, or failure to comply with insurance plan requirements.

3. **Third Party Collection.** I acknowledge that the System 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, the System may place the account back with the EBO Servicer, or, at the option of the System, 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 System 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 System in pursuing collections, including, but not limited to, reasonable attorneys' fees, and (b) any court costs or other costs of litigation incurred by the System.

4. **Assignment of Benefits.** I irrevocably assign and transfer to the hospital all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the hospital of all insurance and health plan benefits payable for this hospitalization or for these outpatient services. I agree that the insurer or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this hospital to perfect, confirm, or validate this assignment.

   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 System, 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.

I hereby **irrevocably appoint** the System as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, and third party liability carrier or, any other responsible third party ("Responsible Party") for any and all benefits due me for the payment of charges associated with my treatment. This assignment shall not be construed as an obligation of the System to pursue any such right of recover. 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 System in collection payment from any such Responsible Party in my name. If I receive payment directly from any source for the medical charges associated with my treatment, I acknowledge that it is my duty and responsibility to immediately pay any such payments to the System(s).

5. **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.

6. **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.

7. **Private Room.** I understand and agree that I am (or Guarantor is) responsible for any charges associated with the request and/or use of a private room.

8. **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 System or an agent of the System or an independent physician's office for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

9. **Other Acknowledgements**

Personal Valuables. As a patient, I am encouraged to leave personal items at home. 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 of any money, or personal property of patient, including, but not limited to, jewelry,

documents, eyeglasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices, or other articles that are not placed in the safe. Hospital liability for loss of any personal property deposited with the hospital for safekeeping is limited by law to five hundred dollars ($500) unless I receive a written receipt for a greater amount from the hospital.

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 who 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. I, the undersigned, acknowledge and verify that I am the legal guardian or custodian of the minor/incapacitated patient.

10. **Patient Self Determination Act.** I have been furnished information regarding Advance Directive (such as durable power of attorney for healthcare and living wills). Please initial or place a mark next to one of the following applicable statements:

	I executed an Advance Directive and have been requested to supply a copy to the hospital.		I have not executed an Advance Directive, wish to execute one, and have received information on how to execute an Advance Directive.		I have not executed an Advance Directive and do not wish to execute one at this time.

11. **Instruction in Patient Rights and Organization Ethics Committee.** The Patient Rights and Organizational Ethics Committee is available to provide a consultation mechanism to address ethical dilemmas and assistance in resolution of conflicts surrounding care and treatment decisions. Consultation from the committee can be made by the attending physician, any member of the health care team, the patient, the patient representative, or any family member. To access the Mee Memorial Patient Rights and Organization Ethics Committee, contact the Social Services Department at (831) 386-7493.

12. **Authorization for Receiving Automated Messages to a Cellular Telephone or Electronic Mail.** I authorize System, through its contractors, EBO Servicers, business associates, agents and/or affiliates, to contact me

by SMS text message or email in order to serve me better, including, but not limited to, receiving discharge instructions and other healthcare communications, or to service my account or collect any amounts I may owe. I may be contacted at any telephone or email address associated with my account(s) with System or its EBO Servicers, including wireless telephone numbers [Note: additional charges may apply. Please check with your mobile carrier]. I agree that methods of contact may include using pre-recorded or artificial voice messages and/or automated dialing systems or texts (SMS), as applicable. I understand to stop future communications in this manner I must contact System to update my information. I understand there is the potential for disclosure of my information by receiving information in this manner. I further understand that I am under no obligation to authorize System to send me text messages in order to receive health care services

Patient Initials: _________________________

13. **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 operation and other prescribed and permitted uses and disclosures. I understand that this information may be disclosed electronically by the System, its providers and/or the System and provider's business associates. I understand that I may contact the hospital Privacy Office designated on the notice if I have a question or complaint.

    Acknowledge: ____________________ (Initial)

14. **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 System.

    Acknowledge: ____________________ (Initial)

15. **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, 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)

16. **Additional notifications.**
    A. **Family member/Representative notification:**
    ☐ Decline family member/representative notification.

    Family member/designee name:______________________________ Phone:______________________

    Date contacted:____ Time contacted:_______________

PLACE LABEL HERE

B. Name of family member or caregiver who may assist you in post-hospital care:

☐ Decline to select family member or caregiver.

Family member/caregiver name:______________________________ Phone:______________________

C. Primary care physician notification:

Physician name:____ Phone:______________________

Date contacted:____ Time contacted:______________

D. Discharge Planning:

You or your family member/representative may request a discharge planning evaluation by a hospital case manager prior to discharge.

I, the undersigned, as the Patient or Patient Representative, or as the legal guardian for a minor/incapacitated Patient, hereby certify I have read and fully and completely understand this Conditions of Admission and Consent for Outpatient Care and I have signed this Conditions of Admission and Consent for Outpatient Care knowingly, freely, and 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.

Signature:____

Patient/Patient Representative **Date / Time**

If you are not the Patient, please identify your relationship to the Patient:

☐ Spouse	☐ Parent	☐ Legal Guardian	☐ Healthcare Power of Attorney
☐ Sibling	☐ Neighbor/Friend	☐ Guarantor	☐ Other______________________________

Witness:____

Signature **Title**

Additional witness signature and title *(required for Patients unable to sign without a representative or Patients who refuse to sign):*

Witness:____

Signature Title

Mee Memorial Healthcare System
300 Canal Street • King City, CA 93930
(831) 385-6000

PLACE LABEL HERE

Conditions of Admission and Consent for Outpatient Care (Emergency Department Part II)

8560.018 (Rev. 7/8/21 – FINAL)