

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Cleveland Clinic Hospital and/or its affiliated facilities (each and all of them referred to as "CC" in this form).

Consent to Health Care Services: I am requesting that health care services be provided to me (or my minor child or the patient named below) at CC. I voluntarily consent to all medical treatment and health care-related services that the caregivers at CC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my CC caregiver. My blood may be used to perform routine quality assurance testing. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

I understand that CC may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

Financial Responsibility:

a. Subject to applicable law and the terms and conditions of any applicable contract between CC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay CC for any balance not paid under the "Assignment of Benefits/Third Party Payers" paragraph below.

Or, b. Subject to applicable law and the Cleveland Clinic Health System Financial Assistance Policy, and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay CC for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to CC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding CC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by CC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

Patient Rights and Responsibilities: I have received a copy of the Cleveland Clinic Health System Patient Rights and Responsibilities brochure or the Cleveland Clinic Health System Welcome Guide.

Uses and Disclosures of Health Information: I have received Cleveland Clinic Health System's Notice of Privacy Practices. The Notice of Privacy Practices explains how Cleveland Clinic Health System may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let Cleveland Clinic Health System use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the below-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by CC, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent CC or provide assistance to CC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the below named patient's) health care, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that CC has already relied on my consent.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to CC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from CC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who

may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from CC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I hereby consent and grant to CC the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by CC. I understand that I have the right to request cessation of recording or filming at any time. I agree to release and forever discharge CC, its agents, officers and employees from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

Teaching Facility/Clinical Studies: CC is a teaching facility. Doctors and others in training may be involved in my (or the below-named patient's) health care. Many CC patients participate in clinical studies. I can ask my (or the below-named patient's) doctor questions about having health professionals in training involved in the care and about participating in clinical studies, and I can explain any views I have. Clinical studies at CC go through a special process required by law that reviews patient welfare and privacy. CC patients usually consent in writing to participate in clinical studies. Sometimes family members or other surrogates are asked for consent when patients are not mentally able to give their own consent. Patients are encouraged to discuss how they feel about being research participants with family members so they will know the patients' wishes if asked.

Valuables/Limitation of Liability: I understand that I should not bring valuables (cell phone, electronic devices, medical equipment, jewelry, money, irreplaceable documents, etc.) with me to CC. If I choose to bring valuables to CC, I AGREE THAT CC SHALL NOT BE RESPONSIBLE FOR VALUABLES UNLESS THEY ARE DEPOSITED IN THE ADMINISTRATIVE SERVICE CENTER LOCATED IN THE HOSPITAL ADMITTING DEPARTMENT. If I do deposit valuables, CC's LIABILITY IS LIMITED to loss or damage caused by willful or wanton negligence. If I do not deposit valuables in the administrative service center, CC is not responsible for them, even if I (or the patient named below) give(s) them to other CC personnel. I also understand that CC may tell me not to use a valuable at any time. Items in CC's Lost and Found are given to charity after 30 days.

By signing below, I am indicating that I have reviewed and acknowledge and consent to the terms described above.

In Person Consent	
Signature of Patient or Responsible Party	Date/Time
X _____	_____
Printed Name of Patient (or Responsible Party if not the Patient)	Responsible Party's Relationship to Patient
_____	_____
Phone Number(s)	
Home _____ Cellular _____	

-OR-

Telephone Consent	
Printed Name of Individual Providing Telephone Consent	Date/Time
_____	_____
Printed Name of Patient (or Responsible Party if not the Patient)	Responsible Party's Relationship to Patient
_____	_____
Phone Number(s)	
Home _____ Cellular _____	