Patient Consent and Agreement for Brown University Health

Consent to Examination and Treatment

I understand that as a patient at any Brown University Health Hospital (Bradley, Newport, Rhode Island, The Miriam), their Clinics, Gateway Healthcare, Brown Health Medical Group, and Telemedicine Visits ("Care Sites"), I may need various medical examinations, diagnostic procedures, medications, and therapies to diagnose and treat my medical condition. I agree to undergo these examinations and procedures as deemed appropriate by my care providers, also known as my "Care Team." During these processes, tissue and biologic fluids like blood or urine may be collected for diagnostic, educational, quality improvement, scientific, or certain research purposes. Non-textual data such as photographs, videotapes, audiotapes, or digital recordings might be taken for identification or documentation purposes, unless I choose to decline. These recordings may also be used for professional credentialing or certification, publication in medical journals, or presentations at seminars and conferences. If these non-textual data are to be used for research purposes or are not fully de-identified according to HIPAA guidelines, I will be asked to give a separate consent for their use.

I understand that healthcare is not an exact science, and no guarantees have been made about the effectiveness of any procedures, treatments, examinations, or other healthcare services. My Care Team will inform me about the most reasonable course of action for my condition, and the decisions will be made with my best interests as a patient in mind. I retain the right to withhold consent for any medical or surgical procedure or other healthcare service. The Care Site also has the right to decline to perform any procedure if I, or my representative(s), have not provided clear informed consent. I acknowledge that if I or my representative(s) withhold consent for a recommended procedure, the treatment may be partially or wholly ineffective.

Consent to Examination and Treatment of Newborn

If I give birth during this encounter, I consent to providing necessary treatment to my newborn(s).

Assignment of Insurance Benefits & Authorization to Release Health Care Information to Provider

I understand that providers at some Care Sites may not be employees of that particular Brown University Health Care Site. I authorize the direct payment of my health insurance benefits to the relevant Brown University Health entity and any Brown University Health-affiliated provider offering services during this hospitalization or visit. I am aware that I am responsible for charges not covered by my insurance and for meeting my health plan's contract requirements. In some cases, I might receive separate bills for emergency care

services, x-ray interpretation, or other diagnostic imaging, and that some providers' services may be billed separately from the Care Site services.

Medicare Authorization

If I am covered by Medicare, I agree to the conditions of admission for hospitalization outlined in this agreement. I certify that the information I provided during my application for the Medicare Program (Title XVIII of the Social Security Act) is accurate. I request that payment for any authorized Medicare benefits to be made on my behalf be made to the Care Site or its employed providers. I authorize the release of any medical or other information about me to the Centers for Medicare and Medicaid Services (CMS) and its agents to determine my eligibility for Medicare benefits or related services.

Financial Responsibility

I agree that Brown University Health may contact me via telephone at any number associated with my account, including wireless numbers, for account servicing and collection purposes. This may include the use of pre-recorded or artificial voice messages and automatic dialing services. I also authorize the Care Site to use any outstanding credit balance I may have to settle any outstanding account balance I may owe to a different Care Site before processing any patient refund to me.

Electronic Communications

I consent to receive administrative electronic communications from Brown University Health, which may include emails, text messages, phone messages, or other electronic means for various purposes such as appointment scheduling or reminders, program registrations, surveys, inquiries, billing/payment matters or notifications concerning the MyChart patient portal, as applicable, I acknowledge that the privacy and security of electronic communications cannot be guaranteed, and parties with whom I have shared my electronic addresses or phone numbers might be able to access my personal health information from these transmissions.

Right to Advance Directives

If I am admitted as an inpatient or observation patient, I have been informed of my right to make medical decisions and to have advance directives, such as a living will or Durable Power of Attorney for Health Care. It is my responsibility to provide my Care Team with a copy of my advance directive to ensure my wishes are known and respected.

Personal Belongings

I understand that Brown University Health cannot be responsible for my personal belongings, and I assume the risk of loss if I bring them to any Brown University Health Care Site.

Personal Electronic Devices

The use of personal electronic devices by patients and visitors for taking or transmitting photographs, video recordings, or audio recordings of patients, medical staff, or hospital employees is prohibited.

Notification of Security Camera Use

Security cameras are in place in certain public areas of the hospital, including some patient areas.

Brown University Health Pharmacy Concierge Meds to Beds Service

I acknowledge and consent to enroll in the concierge Meds-2-Beds program if I am an Inpatient of Rhode Island Hospital or The Miriam Hospital or an Inpatient or Emergency Department patient of Newport Hospital, during Brown University Health Pharmacy's operational hours. This service is available during Pharmacy's operational hours at specific facilities.

I will automatically be enrolled in Brown University Health's concierge Meds-2-Beds program, which aims to help with prescription issues and ensure that I have my discharge medications before leaving. Brown University Health's retail pharmacy staff will perform necessary benefits investigations, secure prior authorizations, fill my discharge medications, and deliver them to my room. If I wish to decline this service at any point up to delivery, I can inform my care team or a representative of Brown University Health Pharmacy, and they will reverse any claims and help transfer my prescriptions to a pharmacy of my choice.

Consent to Brown University Health (42 CFR PART 2) Program to Disclose My Drug/Alcohol Treatment Information

If I am receiving drug or alcohol (substance use disorder-related) treatment at any Brown University Health-affiliated provider entity, I also acknowledge and consent to the following:

- I allow the Brown University Health program to disclose my substance use disorder-related claims and encounter data, including my history, diagnosis, medication, and treatment, to my MyChart record (my electronic health record at Brown University Health) and to my treating providers and professionals who are

authorized to access my MyChart record, whether or not they practice at a Brown University Health affiliate. This consent will expire if Brown University Health, or its successor organization, and MyChart, or its successor electronic medical records system, cease to exist.
• I further consent to allow Brown University Health to make referrals for certified peer recovery specialist services.
• I understand that I can revoke this consent in writing with notice to the Brown University Health program(s) where I have received drug or alcohol treatment at any time, but it will not affect disclosures made in reliance on my original consent.
• I have the right to request a list of entities to which my drug or alcohol treatment information has been released based on this consent, limited to disclosures made within the past two years.
• By signing this consent form below, I acknowledge that I understand this consent form, and that it means my treatment information that is protected under 42 CFR Part 2 can be released to my MyChart record and accessed by my treating providers and professionals.

Telemedicine Consent

If the visit is conducted via telemedicine:
• I consent to discussing my confidential and protected health information (PHI) and receiving treatment through interactive audio, video, or data communications (telemedicine) as if we were having a discussion at the hospital or treatment site.
• I can withhold or withdraw consent at any time without affecting my future care, treatment, or program benefits.
• Information disclosed during my telemedicine session is generally confidential under law, except in certain mandated or permitted circumstances, such as reporting abuse or threats of violence.
• I will participate in telemedicine from a private area.
• If I participate in group therapy via telemedicine, I agree not to discuss, record in any way (video, audio, photograph, screen capture, etc.), or share any private information about anyone in the group or about the content of the discussion with anyone outside of the other group participants or my treatment team.
Patient Consent and Agreement (date: 11 21 2024)
• There are risks associated with telemedicine, such as disruptions, technical failures, or unauthorized interception of information by unauthorized persons during transmission or storage.
• I understand that telemedicine services might not be as comprehensive as faceto-face services, and I may discuss other treatment options if necessary.
• I acknowledge that despite best efforts, my condition may not improve or could worsen.
• My health insurance plan will be billed for telemedicine services, and I may be

responsible for co-payments or deductibles if applicable.

Acknowledgment

By signing this consent form, I confirm that I have read and understood its contents. I am the patient, the patient's parent/guardian, or a duly authorized patient representative, capable of reviewing and accepting the terms. I understand that the visit may occur in-person or via telemedicine.

This paper copy is for your information only; the electronic signed original is incorporated into your Medical Record.