Northern Light Health

- ☐ A.R. Gould Hospital
- ☐ Beacon Health
- ☐ Blue Hill Hospital
- ☐ C.A. Dean
- ☐ Eastern Maine Medical Center
- ☐ Home Care & Hospice-Palliative Care
- ☐ Inland Hospital
- ☐ Laboratory
- ☐ Lakewood
- ☐ Maine Coast Hospital
- ☐ Mayo Hospital
- ☐ Medical Transport
- ☐ Mercy Hospital
- ☐ Pharmacy
- ☐ Sebasticook Valley Hospital

Patient Identification

CONSENT TO TREATMENT
GUARANTEE OF PAYMENT
ASSIGNMENT OF BENEFITS
PROTECTED HEALTH INFORMATION
CONSENT TO CARE

NONDISCRIMINATION STATEMENT: Northern Light Health and its affiliates (Northern Light Health) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language. Northern Light Health does not exclude people or treat them differently because of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language.

Northern Light Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-888-986-6341. If you have a TTY, you may also dial 711 Maine Relay.

If you believe that Northern Light Health or any of its affiliates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language, you can file a grievance with your Northern Light Health Civil Rights Coordinator, 797 Wilson St., Suite 4, Brewer, ME 04412, 1-866-769-8363 **(telephone),** 1-207-989-1420 **(fax),** or at nondiscrimination@northernlight.org **(email)**. If you need help filing a grievance, your Northern Light Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-986-6341 (ATS : 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-986-6341 (TTY: 711).

Oromo (Cushite): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-986-6341 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-986-6341（TTY：711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-986-6341 (TTY: 711).

Tagalog (Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-986-6341 (TTY: 711)

Cambodian (Khmer): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ *1-888-986-6341 (TTY: 711)*។

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Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-986-6341 (телетайп: 711).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-986-6341 (رقم هاتف الصم والبكم: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-986-6341 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-986-6341 (TTY: 711)번으로 전화해 주십시오.

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-986-6341 (TTY: 711).

Nilotic (Dinka): ***PIIɔ KENE****: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-888-986-6341 (TTY: 711)*

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-986-6341（TTY:711）まで、お電話にてご連絡ください。

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-986-6341 (TTY: 711).

CONSENT TO CARE

This is not an informed consent.

I voluntarily consent to such routine diagnostic procedures; medical and/or surgical care; and/or hospital care as determined by my physician/provider and/or his/her designees to be necessary and desirable based on his/her exercise of professional judgment.

I understand that if under Maine law I am a surrogate caretaker for a minor, then I am required by law to make a reasonable good faith attempt to inform the minor's parent/guardian of the need for healthcare and that the care was received. I certify that I have complied or will comply with these requirements.

Students in medicine, nursing and other healthcare professions (under appropriate supervision) may be involved in my care.

My treatment or physical condition may be photographed or electronically recorded in order to provide, coordinate or manage my care. A photograph of me may be included in my record for identification purposes.

I understand that my physician/provider will explain to me the purpose and anticipated benefits of, and the usual and most frequent risks and hazards involved in, the diagnosis and/or treatment of any illness or injury as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examinations, tests or treatment.

I understand I will be offered the opportunity to make an Advance Directive and to place it in my medical record to give instructions about my care if I become unable to do so.

I am aware that, if my heart or lungs should suddenly and unexpectedly stop working, cardio-pulmonary resuscitation (CPR) will be performed on me except in certain limited circumstances. CPR may involve electric shock to the heart, mechanical breathing assistance through a tube inserted by mouth or nose, drugs and other therapies. I can discuss my care, Advance Directive and CPR with my physician/provider.

I am aware that healthcare, including the practice of medicine, is not an exact science and I acknowledge that no guarantees have been made to me as to the result of examinations, tests or treatment.

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If I am receiving care at Northern Light Blue Hill Hospital, Northern Light C.A. Dean Hospital, Northern Light Mayo Hospital, Northern Light Sebasticook Valley Hospital or Northern Light Mercy Hospital's Fore River campus, I understand that a physician may not be present in the hospital during all hours services are furnished to me. At those times when a physician is not in the hospital there will be a Nurse Practitioner or Physician Assistant available with back-up by an on-call physician.

Any or all of my health information will be shared with other healthcare practitioners and healthcare facilities, and with payers or persons engaged in the payment for healthcare, for the purposes of managing or coordinating my care.

GUARANTEE OF PAYMENT AND ASSIGNMENT OF BENEFITS

I authorize, direct, and assign payment to the hospital, my physician/ provider, and/or any entity furnishing the services by any applicable insurer or other payor of hospital and medical benefits and other sums otherwise payable to me, but not to exceed the regular charges for the care provided to me. I am financially responsible to the hospital and to my physicians/providers for any charges not paid by other payors (including deductibles, co-payments, non-covered services, services not authorized by my physician/provider and penalties assessed by my health plan).

I understand that the hospital and my providers will not knowingly charge or accept payment for care that has caused me serious harm resulting from preventable mistakes and adverse events as defined by state law.

If I wish to pay out of pocket and not have my insurance company billed, I will notify hospital staff. If I do not wish my insurance company to be billed, I will be expected to pay the estimated charges at the time of service with payment in full within 30 days. If I do not make payment in full within 30 days, my insurance company will be billed.

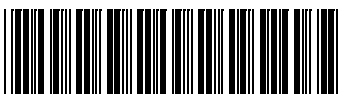
I understand that I will be billed separately for certain diagnostic services and professional services provided by radiologists, pathologists and certain other physicians/providers not employed by the hospital. These professional services also may be provided and billed by another Northern Light Health entity. I understand that I am solely responsible for my personal property (including any valuables, such as jewelry and electronics) unless I have deposited it with the hospital or my provider for safekeeping during my visit or admission. I understand and agree that if I choose to keep my personal property in my possession while a patient, neither the hospital nor my provider or other hospital staff is liable for any related personal injury or property loss or damage.

PROTECTED HEALTH INFORMATION

To the extent permitted by law, my health information (including my behavioral health information) will be shared with other healthcare practitioners and healthcare facilities, and with payers or persons engaged in the payment for healthcare, for the purposes of managing or coordinating my care.

If I object to the hospital or my provider using or disclosing my protected health information as described below, I will **CROSS OUT** any item to which I object. If I do not cross out an item, it will mean I agree:

a. My location within the hospital (room number or department) will be disclosed to people who ask for me by name.
b. Clergy will be given access to a patient list that includes my name and religious affiliation.
c. Members of the clergy, media and law enforcement will be told my general condition if they ask about me by name.
d. Potential healthcare professionals, including individuals who are seeking to learn about potential careers in the healthcare field but who are not currently enrolled in a healthcare education program, may accompany my treating clinicians and associated staff.



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e. My health status, treatment, billing and scheduling will be discussed with other individuals involved in my care or payment for my care. If I want this information discussed with any additional individuals (regardless of their level of involvement), I will list them here:
_____.

f. I authorize the hospital/my provider (or any other person or entity acting on their behalf) to call, text, and/or email any contact numbers or email addresses I provide at registration, including my cell phone number (and leave voice messages if I am unavailable) for the purposes of treatment, appointment reminders, payment for items and services, and resolution of my medical bill. These calls and texts may be automated and include pre-recorded electronic messages.

g. My protected health information will be used in an emergency, if necessary, to identify, locate and notify my family or other responsible persons of my presence in the hospital and my general condition.

h. In the event I am the victim of a disaster my protected health information will be used, if necessary, to assist relief organizations in identifying, locating and notifying my family or other responsible persons of my presence in the hospital and my general condition.

i. I authorize the hospital/my provider to call, text, and/or email me, in order to assess and/or improve patient care.

I understand the hospital/my provider will not condition treatment on whether or not I participate in the statewide health information exchange (HealthInfoNet). The hospital/my provider will not deny me treatment if I do not participate. *(If you need information on how to opt out of HealthInfoNet, please ask.)*

I will consult the Northern Light Health Notice of Privacy Practices if I want to learn about the other ways the hospital and my providers will use and disclose my protected health information.

SIGNATURE

I have read this form, or it has been read to me, and I understand it. I understand that I may have a copy on request. I understand that if under Maine law I am a surrogate caretaker for a minor, then I am required by law to make a reasonable good faith attempt to inform the minor's parent/guardian of the need for healthcare and that the care was received. I certify that I have complied or will comply with these requirements.

Signed: _____ Date: _____ Time: _____
(Patient*)

Signed: _____ Relationship: _____ Date: _____ Time: _____
(Authorized Representative*)

I have received or declined a copy of the a) Northern Light Health Notice of Privacy Practices, b) Patient's Rights and Responsibilities, c) information on the health information exchange including an opportunity to opt out, and d) plain language summary of the Northern Light Health Financial Assistance Policy.

Signed: _____ Date: _____ Time: _____
(Patient*)

Signed: _____ Relationship: _____ Date: _____ Time: _____
(Authorized Representative*)

A parent/guardian or other authorized representative is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should sign in addition to their parent/guardian or authorized representative. Indicate relationship of representative to minor patient.