PENINSULA OUTPATIENT CENTERS
CONSENT AND MEMORANDUM OF AGREEMENT

The undersigned hereby applies for treatment of the above-referenced client ("Client") by Peninsula Outpatient Centers ("Peninsula").

Undersigned is: ☐ Client ☐ Parent/Custodian /Guardian acting on behalf of a child
☐ Conservator ☐ Individual Holding Appropriate Power of Attorney

"Applicant" as used in this document means Client's parent, guardian, conservator, attorney-in-fact, or custodian. As a condition of Client's treatment by Peninsula, the undersigned agrees: (a) to cooperate fully with all measures used or prescribed by Peninsula staff, attending physicians, and consultants for Client's treatment and to maintain a therapeutic setting suitable to Client's needs; (b) if the undersigned is not Client, to encourage Client to comply with recommended treatment; and (c) that Peninsula is interested in maintaining a safe treatment setting for all clients and staff and that if the Client or family should threaten Client's immediate safety or the safety of others, Peninsula may notify the appropriate authorities and Client's care may be discontinued. The undersigned understands, accepts, and agrees to each of the following terms and conditions:

1. Consent to Treatment:

Knowing Client has a condition requiring care or services at Peninsula, the undersigned voluntarily consents to treatment and services by Peninsula and such services or items ordered by Client's physicians or furnished by treating providers at Peninsula, including medication, counseling, and therapeutic and diagnostic services (including labwork). In case of medical emergencies, Peninsula will arrange for Client to be transported to an appropriate medical facility by ambulance, and the undersigned hereby consents to such transfer and services provided to Client by such recipient facility. The undersigned agrees biological samples obtained from Client during the course of Client's care that are de-identified and will otherwise be discarded may be used by Peninsula or third-parties for service validation purposes, medical research and/or educational purposes in compliance with applicable state and federal regulations. Results of treatment at Peninsula cannot be guaranteed, nor can Peninsula be responsible for treatment that is ordered by providers practicing at Peninsula or elsewhere. It is the treating practitioner's responsibility to provide adequate information concerning a proposed treatment and to obtain informed consent before proceeding, except as limited by emergency or other time-sensitive circumstances. Peninsula may obtain signature for such consent. Client/Applicant has the right to question and refuse treatment; however, should a proposed treatment be refused, Peninsula and its associated physicians, employees, agents, and contractors shall be released from any and all liability for failure to provide treatment.

2. Clients Rights and Responsibilities; Peninsula Rules and Regulations:

- The undersigned acknowledges receipt of the Client Rights Handbook, which includes information regarding the EPSDT rights of a child, the right to have a family member, friend, or advocate assist Client, Peninsula's Rules and regulations, and how Peninsula addresses complaints and grievances. The undersigned acknowledges that such rights have been verbally explained in simple language and being provided an opportunity to ask questions about information in the Client Rights Handbook. The undersigned further acknowledges being informed of Client's responsibilities, understands rules may be more or less restrictive depending upon Client's condition, and agrees Client will follow these rules.
- The undersigned acknowledges Client, belongings, and any room/area in which Client has been located may be searched as necessary to ensure the safety of Client, staff, and other clients.

3. Calculation and Payment of Peninsula Charges; Collections; Contacts:

Client is liable and individually obligated for payment of Peninsula's charges on Client's account and the undersigned understands and agrees as follows: (1) Peninsula's charges are set out in a chargemaster, the relevant portions of which may be examined for purposes of verifying Client's account during regular business hours at the business office located at **1420 Centerpoint Blvd, Knoxville, Tennessee, 37932** . Peninsula reserves the right to change the rates in the chargemaster. Charges on Client's account are calculated based on chargemaster rates in effect as of the date charges for items or services are accrued. (2) Client is liable for the uninsured portion of the Peninsula bill, which is due in full when billed. Any amount not paid in full by insurance, for any reason, is the responsibility of Client. (3) Peninsula has both an uninsured discount policy and a charity care discount policy. If Client is uninsured, Client is automatically entitled to a discount on chargemaster rates in accordance with Peninsula's uninsured discount policy. Also, if Client is uninsured and meets the criteria set forth in Peninsula's charity care policy (including, without limitation, income criteria), Client may be entitled to further discounts to chargemaster rates or, in some cases, waiver of charges. Please contact Peninsula's billing office at **(865) 374-5354** for more information about our charity care program. (4) The amount of Client's charges may differ from amounts other clients are obligated to pay based upon each client's insurance coverage, Medicare/Medicaid coverage, or lack of coverage. The amount of any discount from charges varies based on the circumstances applicable to each individual under Peninsula's policies. (5) After reasonable notice, delinquent accounts may be sent to a collection agency and/or attorney for collection. Client agrees to pay the costs of collection, including court costs and attorney fees associated with Peninsula's efforts to collect the amount due. The undersigned hereby authorizes FACILITY and all health care professionals providing care to patient at FACILITY, together with any billing service, collection agency, attorney, or other individual or entity working on FACILITY's or such professional's behalf, to contact the patient and patient's representatives by cellular and home telephone using prerecorded or artificial voice messages, automatic telephone dialing systems or other computer-assisted technology, text messages, and other forms of electronic communication.

4. Medicare/Medicaid Certification and Assignment of Benefits; Health Plan Notice:

The undersigned certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. The undersigned hereby irrevocably assigns to Peninsula all rights, title, and interest in compensation or payments otherwise payable to Client, or received by or on behalf of Client, for Peninsula items or services from any source or payor on file for Client's account, including Medicare/Medicaid/TennCare, insurance companies, HMOs, and any other third-party payor or financially responsible person, not to exceed charges for services rendered. Any person, corporation, or governmental or other entity having notice of this assignment is authorized and directed to pay directly to Peninsula all amounts due for items and services provided to Client by Peninsula. The undersigned hereby assigns to Peninsula and any of its parent entities, affiliates, subsidiaries, or assigns any and all rights and benefits I have or may become entitled to under any policy of insurance, any type of health plan under the Employee Retirement Income Security Act, whether self-funded or otherwise, indemnity agreement, or from any other collateral source or third-party payor of any kind or nature, including all the rights to collect benefits directly from any insurance company, indemnity agreement, health plan covered by Employee Retirement Income Security Act, or from any other collateral source or third-party payor of any kind or nature and any and all right to proceed against any of the same in any action, including legal suit, if for any reason any of the same should fail to make payment of any benefits due. It is my intent to assign to the fullest extent possible any and all rights I have under the Employee Retirement Income Security Act to the hospital and any of its parent entities, affiliates, subsidiaries or assigns without limitation. I further assign to the hospital and any of its parent entities, affiliates, subsidiaries or assigns, the right to the proceeds to pay the chargemaster rate for my bill from any claim and/or any action at law or equity for personal injuries which I may have to the extent allowed by law. Any such person, corporation, governmental or other entity is also authorized and directed to pay benefits directly to the following for professional services rendered related to Peninsula's services: Client's physician and any other physicians or professionals who treat Client at Peninsula and are not employees or agents. The undersigned also consents to release by Client's health plan, insurance carrier, or other coverage to Peninsula and Peninsula's billing service of any eligibility, utilization, or plan data concerning Client's coverage that may be required. Except as otherwise provided in this agreement or by law, Client is financially responsible to Peninsula for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payors, including Medicare and TRICARE/ CHAMPUS/CHAMPVA, do not pay. Medicare will not pay for oral medications received during outpatient visits. Any sums not paid by a third-party payor are Client's obligation.

Client is responsible for all health insurance/health plan deductibles and co-insurance, as well as noncovered or excluded items or services. If it is later determined Client has an HMO or other health plan primary to Medicare and failed to inform Peninsula prior to service of such election, Client shall be responsible for paying the account. The undersigned agrees that a copy of this assignment may be used in place of the original copy. If Client's health plan, insurer, or other coverage requires prior notice/authorization for Peninsula's services, it is Client's responsibility to provide such notification and obtain such authorization. Client hereby assumes financial responsibility for charges incurred because of failure to comply with prior notification/authorization requirements.

5. Indemnification and Hold Harmless:

Client will indemnify and hold Peninsula and all of its directors, officers, employees, and staff, harmless from any claim arising from injury or harm to Client or caused by Client, or damage to Client's property, that results from any cause other than negligence of Peninsula or staff.

6. Advance Directives: Does Client have an advance directive or POST?

☐	**Yes.** *Check all that apply:* ☐ Living will ☐ Durable health care power of attorney ☐ Appointment of health care agent ☐ Physician Order for Scope of Treatment ("POST")	☐ Appointment of Surrogate Form ☐ Declaration for mental health/psychiatric advance directive ☐ Other: _____	☐ **No,** Client does not have an advance directive or a POST.

Please provide a copy of any advance directive/POST to registration staff. The undersigned acknowledges that Peninsula does not honor requests to withhold cardiopulmonary resuscitation (CPR). In the event CPR becomes necessary, CPR will be initiated, 911 will be contacted, and a transfer to an appropriate facility will be made. To the extent Client has made a request for more information concerning advance directives, Client acknowledges being offered an educational brochure on advance directives.

7. Designated Representative:

If Client does not have an advance directive, Client may designate a representative to assist in Client's plan of care, make health care decisions for Client, and receive health care information about Client by having such designated representative sign this agreement in Signature Block B, below.

8. Notice of Privacy Practices; Photograph/Video Consent:

The undersigned acknowledges receipt of Peninsula's Notice of Privacy Practices and authorizes Peninsula to use and disclose Client's Peninsula records consistent with such Notice and applicable law. The undersigned also acknowledges and agrees that Peninsula may photograph or video Client's treatment and that photographs of Client may be taken for use for identification purposes.

9. Consent to Release of Client Information for Treatment, Payment, and Operations Purposes:

Peninsula records, including alcohol and drug abuse records, are protected by various State and Federal laws regarding confidentiality. However, Peninsula works with other providers treating Client, discloses Client's information to obtain payment for services, and uses and discloses client information to operate Peninsula and for quality of care purposes. Therefore, signature on this agreement includes consent to disclosure by Peninsula of Client's entire Peninsula record, including without limitation, assessments, findings, test results, progress notes, treatment plans, summaries, and discharge information, including records pertaining to treatment of psychiatric, substance abuse, and medical conditions, and claims and billing records associated with the same, for dates of service including this registration through discharge from all Peninsula inpatient and outpatient facilities/services. Recipients of such information are all Covenant Health and Peninsula facilities treating Client named in Peninsula's Notice of Privacy Practices ("NPP"); all medical facilities providing emergency or urgent care to Client; any community-based provider to whom Client is transferred or referred for care (e.g., Helen Ross McNabb, Ridgeview Psychiatric Center, Cherokee Mental Health, or other mental health treatment provider to whom Client is referred for care); any person, corporation, or agency on file for Client's account that is or may be liable for all or part of the charges incurred by Client at Peninsula or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including , without limitation, insurance companies, HMOs, preferred provider and managed care organizations, workers compensation carriers, welfare funds, governmental health plans, review organizations, the State of Tennessee and its fiscal agents for Medicaid/TennCare claims, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same; and all accrediting, licensing, and other individuals and organizations described in Peninsula's NPP that are part of Peninsula's health care operations activities. The information is to be released for treatment, payment, and health care operations purposes described in Peninsula's NPP. This consent expires one year after Client's discharge date or final resolution of Peninsula claims for payment (including final resolution of any collections action, administrative proceeding, or litigation pertaining to such claims), whichever is later. The undersigned has the right to rescind this consent at any time, and such rescission shall be effective except for actions already taken in reliance on it.

10. Consent to Testing for Communicable Diseases; Consent to Release Information:

The undersigned consents for Client to be tested for any communicable disease or condition, including without limitation, hepatitis, HIV, or other infectious disease, if and when a client, a health care practitioner or other individual furnishing services to Client at Peninsula, a Peninsula employee, or an emergency aid worker has a potential exposure from Client. If such testing becomes necessary, it will be performed at no charge to Client. In the event an emergency aid worker is potentially exposed to a life-threatening disease by Client, Peninsula is hereby authorized to release information about Client to a requesting authority so it can be determined if Client has or had such an infection and could have transmitted it to such emergency aid worker.

11. Amendments; Authority Of Applicant; Duration:

Revisions to this agreement are not effective or enforceable unless accepted in writing by a Peninsula corporate officer. If the undersigned is not Client, such individual hereby represents and certifies that he/she is Client's authorized representative (or has legal custody of Client) and has all necessary legal authority to enter into this agreement on Client's behalf. Because this agreement concerns outpatient/series services, this agreement shall remain in full force and effect until specifically revoked in

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT AND BY SIGNING BELOW, I HEREBY AGREE TO ITS TERMS. ON REQUEST, I WILL BE PROVIDED A COPY OF THIS DOCUMENT.

SIGNATURE BLOCK A: CLIENT/APPLICANT					
SIGNED			PRINTED NAME		
RELATIONSHIP TO CLIENT:					
DATE			TIME		AM/PM
WITNESS:			IF CLIENT IS UNABLE TO SIGN, THE REASON: _____		

OPTIONAL SIGNATURE BLOCK B: COMPLETE ONLY WHEN CLIENT DESIGNATES A REPRESENTATIVE Client requests that Peninsula disclose to the individual designated below Client's Peninsula treatment and payment records so that such representative can assist in Client's plan of care, make health care decisions for Client, and receive Client's health care information. The designated representative signifies agreement to the same by signature below. Client's consent is subject to revocation at any time except to the extent action already has been taken in reliance on it. This consent will terminate on Client's discharge from Peninsula.					
CLIENT SIGNATURE			PRINTED NAME		
DESIGNATED SIGNATURE REPRESENTATIVE			PRINTED NAME		
DATE			TIME		AM/PM
WITNESS:					