UCONN HEALTH

(Patient Identification)

UConn Health Consent and Conditions of Treatment

1. **Treatment Consent:** I, the undersigned, voluntarily consent to provision of health services to me or to the patient for whom I am signing, including medical and dental treatment, as considered necessary and/or advisable by healthcare providers of UConn Health at all locations, including but not limited to UConn John Dempsey Hospital, UConn Medical Group, UConn School of Medicine, UConn School of Dental Medicine including University Dentists, and UConn Health Pharmacy Services, Inc. (together "UConn Health"). This consent addresses physical and mental examination, diagnostic testing, imaging, nursing, technical services, therapy services, laboratory services, the taking of audio and/or visual recordings including videos, photos, and other images for diagnostic or therapeutic purposes, and other non-invasive or minimally invasive procedures and treatments (together "Treatments"). I understand that properly supervised fellows, residents, dental students, medical students, student nurses, and other healthcare students/ learners may be present for or participate in observation, demonstration, and/or Treatment.
   I understand that additional consent may be needed before invasive procedures or procedures with certain risks, such as surgery, and for certain services and visit types, including telehealth.
   If applicable, and in accordance with reprocessing guidelines approved by the Food and Drug Administration, I understand that UConn Health may reuse single-use or disposable items under certain permitted circumstances.
2. **Medical Staff and Dental Faculty:** I understand that some practitioners at UConn Health, including those providing specialized on-call services, may not be employed by UConn Health. The patient may receive a separate bill from these practitioners.
3. **Release of Patient Information:** UConn Health collects demographic information, including patient name, age, address, sex, payer status, and other similar information. This information is used for general business purposes as described in the current UConn Health Notice of Privacy Practices (the "Notice"). UConn Health collects clinical patient information, including information relating to HIV, psychiatric, drug or alcohol treatment and may, subject to restrictions described in the Notice, disclose any such information for purposes defined by applicable Federal and State of Connecticut legal or statutory requirements. See the Notice for detailed use and disclosure information, including permissions and practices related to research.
4. **Research Contact:** I understand that, unless a patient has opted out, UConn Health may contact the patient to determine interest in participating in a particular study or research activity. See the Notice for additional information.
5. **Assignment of Insurance and Similar Benefits:** I understand that a patient's health insurance or other type of payment coverage for Treatment will be applied to charges for a patient's services provided at UConn Health unless a self-pay exception applies. This applies to those services provided by non-employed practitioners, for which independent payment arrangements may need to be made. Patients eligible for Medicare authorize UConn Health to bill and collect from Medicare directly. Charges not covered by health insurance or other Treatment payment coverage, including Medicare or any supplementary insurance, are the responsibility of the patient. UConn Health may disclose all or any part of the patient's record pertaining to an episode of care, including information relating to Treatment for HIV, psychiatric conditions, and alcohol and drug use, to any person or corporation liable under contract to UConn Health or to the patient, a family member, or employer of the patient for all or part of UConn Health's charges including but not limited to medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.
6. **Financial Agreement:** I agree, whether signing as a patient, parent of a minor child, legal guardian, legally authorized representative, or conservator of the patient, and whether or not insured or a member of a health maintenance organization, that I am obligated to pay the rates and charges UConn Health has on file with the Connecticut Department of Public Health (https://ohsnotificationandfilings.ct.gov/Home/Index) and/or those charges provided via financial estimate. If the account is referred to collection, I will pay reasonable collection expenses, including attorney's fees.
7. **Methods of Contact:** To service an account, collect amounts owed, and communicate post-encounter survey opportunities, I agree that UConn Health may contact me at any telephone number associated with the account, and I

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understand that carrier message and data rates may apply. Methods of contact may include text messages, recorded or artificial voice messages, or use of automated dialing systems. I agree to notify UConn Health of any changes to relevant telephone number(s).

8. **Advance Directives:** I understand that if UConn Health has a patient's valid advance directives on file, UConn Health will make a good faith effort to follow the instructions of those advance directives when the patient is incapable of making Treatment decisions. UConn Health may suspend advance directives during surgical procedures and the related post-operative period.
9. **Personal Valuables/Personal Property:** UConn Health encourages patients and visitors to leave personal belongings and valuables home when possible. UConn Health is not responsible for loss of or damage to money, jewelry, documents, electronics, or other personal property. Personal property includes but is not limited to dentures, eyeglasses, and clothing. Potentially dangerous or disruptive belongings are not permitted at UConn Health locations and may be confiscated. Such belongings include but are not limited to weapons, electrical appliances, tools, nicotine and tobacco products, and drugs or medications not prescribed for the patient's Treatment.

I have read, understand, and accept this **Consent and Conditions of Treatment**. I have been offered a copy of the current UConn Health Notice of Privacy Practices and the UConn Health Patient Rights and Responsibilities. This **Consent and Conditions of Treatment** may not be changed; any changes will have no force and effect.

_____ _____

Print Name **Date** **Time ☐ AM ☐ PM**

_____ _____

Signature* **Relationship to Patient**

***** Provide proof of relationship unless self or parent of a minor patient

If patient or legally authorized representative unable to sign:

☐ **Patient or Legally Authorized Representative provided verbal consent, reason:** _____

Staff/Witness: _____ Date: _____ Time: _____

☐ **Unable to obtain consent, reason:** _____

Staff/Witness 1: _____ Date: _____ Time: _____

Staff/Witness 2: _____ Date: _____ Time: _____

UCONN HEALTH USE ONLY:

Photo Identification Validated: ☐ Yes, type: _____ ☐ No, reason: _____

UConn Health requires use of an interpreter for any patient or legally authorized representative whose preferred language is not English. ***If a qualified interpreter used for consent:***

Qualified Interpreter Name: _____

☐ In-person ☐ Over phone, #: _____ ☐ Through video, site: _____