+rmc
Regional Medical Center

MRN:
Patient Name:

(Patient Label)

TERMS AND CONDITIONS OF ADMISSION AND MEDICAL SERVICES AGREEMENT

READ CAREFULLY BEFORE SIGNING

1. RMC: Regional Medical Center of Orangeburg and Calhoun Counties (RMC) is comprised of an acute care hospital, freestanding care center(s), hospital-based clinics, physician care clinics, and medical staff. I understand and acknowledge that many physicians and surgeons furnishing services to me, including, but not limited to, the radiologist, pathologist, anesthesiologist, and the like, are independent contractors and are not employees or agents of the hospital. I understand that I may receive separate bills for services from such independent contractors.

2.MEDICAL CONSENT: I consent to medical treatments and procedures, imaging, drawing blood for tests, medications, injections, taking of medical photographs, videotaping, laboratory procedures, and other hospital or health care services rendered to me under the general and special instructions of the physicians or other health care professionals assisting in my care. I also consent to my admission to the RMC acute care hospital if this is necessary for my care. To protect myself, and others, I give permission to have blood drawn and tested for infectious diseases, including, but not limited to, HIV (AIDS virus), Hepatitis B, and COVID-19. I understand the results of the test will be treated confidentially (subject to legal reporting requirements) and will be made available to my physician and care team. If my blood tests positive for any reportable disease, the results will be reported to the state health department (SCDHEC) and the United States Center for Disease Control (CDC), according to applicable law. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination or health care services rendered by RMC.

3.TEACHING AND RESEARCH [OPTIONAL]: RMC conducts teaching and research. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, imaging, rehabilitation therapy), post-graduate fellows, and other trainees may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of RMC's medical education programs. I also understand that an institutional review board approves projects conducted by RMC-affiliated researchers in accordance with state and federal law. As a result, I understand that I may be contacted and asked to participate in research studies but I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

4. PERSONAL ITEMS/VALUABLES: RMC maintains locked storage for the safekeeping of money and valuables. RMC shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, or other articles of unusual value and shall not be liable for loss or damage to any personal property, unless deposited in a safe or locked storeroom. Notwithstanding the foregoing, the liability for loss of any personal property deposited with RMC shall be no more than $500.00. I understand that the hospital may search my possessions for items which may be considered dangerous to patient safety and the welfare or safety of employees or other third-parties.

5. RELEASE OF MEDICAL INFORMATION: As a patient of RMC, I will be asked to submit certain personal information, such as my address and phone number, Social Security number, insurance information, medical history, and prior medical treatment. The principal purpose for requesting this information is to ensure accurate identification, continuity of medical care, and payment for such care. As required by RMC, furnishing all information requested is mandatory unless otherwise noted. I understand that failure to provide such information may affect my medical care and/or insurance benefits and coverage.

RMC will obtain my written authorization to release information about my medical treatment, except in those circumstances when RMC is permitted or required by law to release information (see RMC' Notice of Privacy Practices for a description of the specific circumstances under which RMC may release this information). For example, RMC may release a copy of my patient record to health care providers, health plans, governmental agencies, and workers' compensation carriers. Additionally, I understand that if I am diagnosed with a reportable disease in South Carolina, RMC is required by law to report my diagnosis to governmental organizations such as the SCDHEC and CDC.

6. FINANCIAL AGREEMENT: I understand that even if I have insurance, I may be financially responsible for some or all of my medical services. For instance, if I have a co-pay or deductible, I agree to pay the amounts I owe. If I do not have insurance that covers the services or care I receive, I agree to pay RMC for such services or care, including RMC physician services, in accordance with the prevailing fees and rates adopted by RMC. I also agree to pay for other professional services provided at RMC by other health care providers. If I am unable to pay, I understand I may qualify for public assistance, special payment arrangements, and/or charity care. I also understand that when this agreement is signed by my spouse, parent, or a financial guarantor, my spouse, parent, or financial guarantor shall be jointly and individually liable with me for payment, including all collection fees (attorneys' fees, costs and collection expenses), in addition to any other amounts due. Unpaid accounts referred to outside agencies for collection bear interest at the current legal rate. I understand that I will receive messages and calls on behalf of RMC at the numbers provided, including my mobile phone number and email address provided during my registration process. Methods of contact may include using pre-recorded/artificial voice messages, the use of an automatic dialing device, or any other means of communication agreed to in the PATIENT CONSENT TO RECEIVE COMMUNICATIONS.

7. ASSIGNMENT OF BENEFITS (INCLUDING MEDICARE BENEFITS): I authorize and direct payment to RMC of any insurance benefits of any kind, including, but not limited to, health care insurance, third-party liability insurance of any kind, medical payments ("med pay") coverage, employee welfare benefit plan coverage, unemployment compensation disability benefits, workers' compensation benefits/payments, proceeds of all claims resulting from the liability of a third-party payable by any person, employer, or insurance company to or for me, and/or other payment sources which may make payments otherwise payable to or on my behalf for RMC services, including, but not limited to, emergency services, at a rate not to exceed RMC actual charges. I understand that I am financially responsible for charges not paid pursuant to this agreement. I further agree that any credit balance resulting from payment of insurance or other sources may be applied to any other account owed to RMC by me. Patients insured by

Part A of the Medicare Act (as primary payer): RMC shall transfer title prior to use of any property (excluding fixed assets or equipment) furnished or supplied to its patient or other customer in connection with its medical services billed pursuant to Medicare Part A. Notwithstanding this provision, patient accepts that the disposal of medical products or other supplies after use will be governed by RMC infection control and disposal protocols.

In addition, I further warrant and represent that any insurance benefit assigned is valid insurance and in effect and that I have the right to make this assignment. In the event that a claim for payment submitted by RMC to my insurance carrier is denied, I hereby authorize RMC to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy. If my plan or policy is provided pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. § 8901et. seq., this review process will include, but is not limited to, a review by the Office of Personnel Management.

As a participant/beneficiary of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. Section 1001 et seq., I designate RMC as my authorized representative and grant RMC the authority to act on my behalf in pursuing and appealing a benefit determination under the plan. Such authority shall include the right to request and receive a copy of the plan description and/or summary plan description.

I understand and acknowledge that some services provided to me may not be covered by health insurance. If I am covered by Medicare, examples of non-covered services include, but are not limited to: (1) drugs and biologicals that can be self-administered; (2) most routine physical examinations and tests directly related to such examinations; (3) most routine foot care and dental care; (4) examinations for prescribing or fitting eyeglasses or hearing aids; (5) hearing aids; (6) most immunizations; (7) most prescription drugs; and (8) cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Other health insurance plans contain specific rules and policies defining covered and non-covered services and care.

I understand and acknowledge that my insurer may determine that the services I am about to receive are not medically necessary and, therefore, not covered.

PLEASE NOTE: YOU WILL BE PERSONALLY FINANCIALLY RESPONSIBLE FOR ANY SERVICES OR CARE NOT COVERED BY YOUR INSURANCE POLICY OR DETERMINED TO BE NOT MEDICALLY NECESSARY. YOUR SIGNATURE TO THIS DOCUMENT MEANS THAT YOU HAVE AGREED TO PAY FOR SUCH SERVICES OR CARE.

9. E-MAIL AND TEXTING CONSENT: I consent to having appointment reminders sent to me via texting or electronic mail, as well as all other communications described in the PATIENT CONSENT TO RECEIVE COMMUNICATIONS. I understand that if I email or text RMC physicians or others involved in my care that I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that texting and email are not secure communication methods as unencrypted messages could be intercepted.

10. ADVANCED DIRECTIVES: An advance directive is a legal document that allows you to spell out your decisions about end-of-life care ahead of time and indicate who should speak for you if you cannot. It gives you a way to tell your wishes to family, friends and healthcare professionals and to avoid confusion later on.

You may speak with your physician or RMC staff member to understand how to obtain an Advance Directive.

I have an Advance Directive for health care (e.g., Power of Attorney for Health Care) Yes No

I have provided RMC with a current copy of my advance directive. Yes No
If no, it is my responsibility to provide RMC with a current copy of my advance directive.

11. **MEDICAL RECORDS:** Individuals have the right to review their own records, in accordance with RMC policy. Information on these policies can be obtained from the officials responsible for maintaining the information:

Your medical record is maintained by:

Your patient billing information is maintained by:

12. OTHER CONSENTS:

I acknowledge that my cooperation in my plan of treatment is required.

I agree to comply with and obey RMC rules and regulations.

I acknowledge and agree that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury, or even death. I acknowledge that no guarantees have been made to me as to the result of examination, treatment, or care by RMC.

Furnishing all information requested is mandatory unless otherwise noted. Failure to provide such information may affect your medical care and/or any insurance benefits and coverage. This information may be provided: to your referring physician or other health care professionals involved in your medical care; to others to the extent required in connection with collection of accounts or a claim for aid, insurance or medical assistance to which you may be entitled, and may be released as provided by state and federal law. The privacy of your record will be safeguarded.

I have read, agreed to and received a copy of this Terms and Conditions of Service as well as documentation outlining the requirements of the South Carolina Lewis Blackman Hospital Safety Act.

Signature of Patient or Patient Representative

_____

Relationship of Representative to Patient

_____

Signature of Witness _____ Date _____

Second Signature
of Witness _____ Date _____
(Required if patient unable to sign)

Date Time
Interpreter ID # _____ Language Used _____

Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 6) and Assignment of Benefits (Including Medicare Benefits) (Paragraph 7) set forth above.

_____

Date Time Financially Responsible Party