I AGREE THAT ALL BLANK SPACES ON THIS PAGE HAVE BEEN EITHER COMPLETED OR CROSSED OFF AND INITIALED PRIOR TO MY SIGNING.

1. The blood transfusion procedure has been fully explained to me and I have had a chance to have my questions answered. If I am an inpatient, I understand that whatever decision I make about receiving blood will remain in effect for my entire hospital stay. If I am being treated as an outpatient, my decision will remain in effect as long as I am being transfused for the same condition. If I change my mind about the transfusion decision, I will tell my doctor and I will sign a new consent form. I also understand that whatever decision I make will not in any way affect my right to receive medical care and treatment now or at any time in the future.
2. I agree to receive blood or blood products as recommended by the doctors treating me with the knowledge that the transfusion of blood and/or blood products carries a risk of infection including, but not limited to HIV infection (AIDS), hepatitis, other infections, blood transfusion reactions, and /or other complications.
3. I understand that I have the right to refuse transfusions of blood and/or blood products. I understand there are risks of not having a transfusion if it becomes necessary during the course of my treatment. The risks of not having a transfusion if it becomes necessary during the course of my treatment include the possibility that certain procedures cannot be performed, the increased possibility of injury resulting from loss of blood and the possibility of death.
4. I understand there may be alternatives to blood and/or blood products which I have discussed with my health care provider.
   I have read the information on the back of this form and other information that my doctor provided to me.

   YES

Patient Signature:

Signed on 05/08/2022 at 05:06:26

Witness (sign and print, include relationship)

Dennis Vanden Berge - resident
Signed on 05/08/2022 at 05:06:37
26926

I certify that I have explained to the patient the blood transfusion procedure, the risks of transfusion and the possible alternatives, and that I have answered my patient's questions.

Provider Signature & I.D. Number

David S. Constantinescu MD (28086)

Signed on 05/08/2022 at 05:06:40
David S. Constantinescu MD (28086)

I AGREE THAT ALL BLANK SPACES ON THIS PAGE HAVE BEEN EITHER COMPLETED OR CROSSED OFF AND INITIALED PRIOR TO MY SIGNING.

MINOR'S CONSENT: A parent/guardian/authorized representative must consent to care for a patient under age 18, unless there is an emergency, the patient is emancipated, or the patient is seeking care for pregnancy, termination of pregnancy (parental notification required except in certain cases), contraceptive services, sexually transmitted disease, mental health outpatient (over age 13), substance abuse, or blood donation (age 17 or more).

Name of person signing for patient (if applicable):

If not signed by patient, indicate relationship: **Melvalisha Braynen - Mother**

EMERGENCY CONSENT: Not Applicable

TELEPHONIC (WITNESSED) ORAL CONSENT: .

Will this document be interpreted? No Into what language?

PATIENT INFORMATION FOR BLOOD TRANSFUSION

REASON FOR TRANSFUSION: The reason a transfusion is necessary depends on the illness a patient has. Most often transfusions are given to correct anemia (a low blood count) or to handle severe bleeding. The benefit of a transfusion is to improve the patient's condition. When anemia or bleeding is extremely severe, a patient's condition may become life threatening up to the point of death if a transfusion is not given. Your doctors will tell you if you may need a transfusion and will provide you with information that you may need to make the decision about receiving a transfusion.

DESCRIPTION OF THE PROCEDURE: Blood is given by vein (usually an arm vein). The transfusion may be of red blood cells, plasma, platelets or other products made from blood. Your doctors will decide on the amount and type of blood product for your condition.

RISK OF BLOOD TRANSFUSION: Blood transfusion is a common procedure with low risk. Blood is now safer than it has ever been, but is not risk-free. Some problems that may occur are listed below:

- Reactions may include, fever, chills, or a rash during or shortly after transfusion.
- If red cells are transfused, a serious reaction is possible, but very unlikely since all blood is carefully matched before transfusion to avoid these reactions.
- All blood is now very carefully tested for infectious diseases. However, there is still a very small risk that transfusion can transmit diseases. These include, but are not limited to, viral hepatitis (an inflammation of the liver) and HIV infection (the virus that causes AIDS). The risk of being infected with hepatitis is very small and infection with HIV after transfusion is extremely rare. The blood component you are about to receive has passed the current standard safety tests.

I AGREE THAT ALL BLANK SPACES ON THIS PAGE HAVE BEEN EITHER COMPLETED OR CROSSED OFF AND INITIALED PRIOR TO MY SIGNING.

ALTERNATIVES TO TRANSFUSION: When bleeding or severe anemia (which cannot be treated with diet or medication) becomes life-threatening, there is no effective substitute for blood transfusion. There may be situations involving elective surgical procedures where a patient may be able to donate his/her own blood in advance of the surgery. Ask your doctor if this is a recommended option for your health condition.

(CROSS OUT AND INITIAL ANY PARAGRAPHS BELOW WHICH DO NOT APPLY)

I, [redacted] *(name of patient or name of authorized representative acting on behalf of patient)* consent to undergo all necessary tests, medication, treatments and other procedures in the course of the study, diagnosis and treatment of my illness(es) by the medical staff, health care professionals and other agents and/or employees of the Public Health Trust (PHT), including the participation of doctors-in-training (residents), other health care professionals-in-training, medical students and other health care students. **This consent will be effective for one (1) year after the date it is signed at any Jackson Health System Location/Facility and will not expire for services or claims processing for admissions or visits occurring while this consent is in effect.**

1. I have been told the name of the physician who has primary responsibility for my care, as well as the professional's status and professional relationships of other individuals who will be involved in my care. It has been explained to me that in large teaching hospitals like the Public Health Trust/Jackson Memorial Hospital and its other facilities, there may be other physicians and staff involved in my care as well, including doctors-in-training (residents) and health care professionals-in-training.

2. I understand that, except in an emergency or extraordinary circumstances, non-routine and major medical procedures will not be performed upon me until I have had an opportunity to discuss and agree to them with a physician or other appropriate health care professional.

3. I understand that the PHT trains doctors and other health care professionals as a service to the community and I agree to cooperate with this mission of teaching future doctors and other health care professionals to the best of my ability.

4. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee have been made to me as to the results of diagnoses, examinations or treatments in the PHT facilities.

5. I hereby authorize the PHT, its employees, agents and members of its medical staff to take such still photographs, motion pictures, transmissions and/or videotaped recordings that may be necessary for the purposes of treatment, payment, and hospital operations or teaching/training. I understand that photographing, etc. for any other purpose such as public relations or scientific research will require the PHT to ask me for specific permission to do so.

6. I hereby authorize the PHT, its employees, agents and members of its medical staff to provide requested consults via telemedicine from providers not in the same physical location. This may include use of patient medical records, medical images, interactive audio, video and/or data communications and output data from medical devices, sound and video files. I have read and understood this information regarding telemedicine and by signing at the bottom of this consent form I hereby give my informed consent for the use of telemedicine as directed by my physicianteam.

7. I hereby authorize the PHT, its employees, agents and members of its medical staff to either: dispose of any specimens or tissues taken from my body during my hospitalization or treatment; or retain, preserve and/or use the specimens or tissues, as necessary, for quality assessment, teaching/training or administrative purposes.

8. I understand PHT conducts research to help the community and would like to be contacted for research opportunities. I understand that PHT's medical staff, other healthcare professionals, agents and medical researchers may access my medical records for purposes of bona fide research that has been approved by an Institutional Review Board and PHT's designated committee. However, records will not be used to identify me without my permission.

9. I understand that my medical records may be accessed by management of the PHT for the specific purpose of evaluating the ongoing quality and efficiency of care rendered at its facilities and by its employees, agents and medical staff. I further understand that management may use portions of my medical records as necessary for teaching/training and disciplinary purposes, provided that the records will not be identified as pertaining to me specifically without my express written permission.

10. I understand that medical information and records may be released to other institutions, agencies, health care organizations or health care providers, who accept me for medical or institutional care. I further understand that my medical information may be released to my insurer(s), managed care organization(s), governmental entities responsible for my care or who may assist in my care and/or pharmaceutical manufacturers, and their respective agents for purposes including, but not limited to, Utilization Review and Quality Assurance Review, and to support applications for patient assistance programs.

11. I understand that my medical information may be accessed for purposes of my treatment, for payment of my care or for the operation of the PHT. The PHT is authorized to release to any insurance company (ies) having coverage for me (or to my employer if coverage is under a group plan), all or part of my medical records pertaining to this hospital admission.

12. I hereby authorize payment directly to the PHT, such other individuals or entities as may be authorized by the PHT and my treating physician of any benefits due to me in my pending claim and/or any health insurance coverage otherwise payable to me, provided that such direct payments do not exceed the hospital's or physician's regular charges for such treatment or the amount then due and owing.

13. I understand that some of the health care professionals who will provide me care (i.e., radiologist, laboratory) may not accept my insurance coverage and that I may be billed directly for any services that they may provide.

14. I understand that the PHT is not responsible for my valuables should I choose to keep them. This includes but is not limited to dentures, cell phones, computers, eyeglasses, and hearing aids.

15. I agree that a photo static, digital, scanned or faxed copy or transmission of this General Consent and Conditions for Treatment is as valid as the original.

16. I acknowledge that I have been provided with a copy of the Jackson Health System Notice of Privacy Practice describing how Jackson Health affiliated entities and health care providers may use and disclose my health information under the federal law for treatment, payment and health care operations by and of Jackson Health System affiliated entities and health care providers.

17. I authorize JHS, its providers (including service providers contacting me about obtaining potential financial assistance for my account(s) and/or for collection service(s) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present, or future. I agree that methods of contact may include using pre-recorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

18. **Consent to Email or Text Communications:** By my consent below, I authorize the use of any email address or cellular telephone number I provide for receiving information relating to discharge instructions, other healthcare communications, and my financial obligations, including but not limited to: post-operative instructions, physician follow-up instructions, dietary information, prescription information, appointment reminders, payment reminders, patient portal, and links to billing information.

19. I understand that it is my responsibility to change any elections below in the annual consent that I have provided at any time by contacting a Patient Access rep at any JHS location directly, or by calling Patient Access @ 305-585-1111.

Do you consent to receiving calls by telephone as described above?

☒ **Yes** ☐ **No**

May we contact you via email?

☐ **Yes** ☒ **No**

May we contact you via text communications?

☒ **Yes** ☐ **No**

Email Address [redacted]

20. I have been offered and/or received a copy of the following Additional Specific Information (initial all that apply):

_____ Notice of Privacy Practice
_____ Patient Rights and Responsibilities
_____ HB 451 Brochure
_____ Other Specific Items as listed here: _____

21. I have received information regarding Advance Directives_____(initial here and initial what applies below)

_____ I have an advance directive and provided a copy of it.
_____ I have an advance directive but did not bring it with me.
_____ I request an advance directive package to review.
_____ I am being re-admitted and already have an advance directive in my records.
_____ I am not interested in executing an advance directive.

22. Hospital Directory & Patient Visitor Preference:

Jackson Health System respects and promotes the patient's right to designate visitors of their choosing and to accommodate visitation whenever possible. There are certain circumstances for health and safety reasons that visitation may not be allowed, and/or the hours and number of visitors may be restricted. Under the circumstance where I decide to change my election, it is my responsibility to contact a Patient Access representative and complete new consent. Below please select one of the options which specifies how you would like to appear in the hospital's directory:

_____ Preference A — No Information: I prefer not to be listed in the hospital's directory and no visitors during my hospital stay.

_____ Preference B — Restricted Visitors: I prefer to be listed in the hospital's directory however with limited visitor access. I understand I will receive a security access code that I may provide to individuals I select to visit during my hospital stay.

X_____ Preference C — No Restrictions: I would like to be listed in the hospital's directory and receive visitors during my hospital stay

23. **Assignment of Benefits:** I hereby authorize payment directly to the PHT, such other individuals or entities as may be authorized by the PHT and my treating physician of any benefits due to me in my pending claim and/or any health insurance coverage otherwise payable to me, provided that such direct payments do not exceed the hospital's or physician's regular charges for such treatment or the amount then due and owing.

24. I hereby irrevocably assign and transfer to Jackson Health System (JHS) and its other facilities all rights, title, and interest in the benefits payable for services rendered by JHS, provided in the policy (ies) of insurance, but shall not be construed to be an obligation of JHS to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I will pay JHS for all charges incurred or alternatively, for all charges in excess of the sums actually paid pursuant to said policy (ies). In fact, to take measures on my behalf as may be necessary to collect any such claims or insurance proceeds including but not limited to any legal action necessary for the collection of the insurance proceeds.

25. By my signature below, I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I further request payment of medical insurance benefits either to myself or the party who accepts assignment.

EMERGENCY CONSENT: Patient is unattended by legal guardian, health care surrogate or proxy and/or is unable to sign consent for treatment necessary to correct or stabilize a serious medical condition(s) demanding immediate medical attention. I certify that this condition will endanger life, limb, or health of the patient and authorize emergency procedures.

Physician's Signature & I.D. Number _____ Date/Time _____

Physician's Signature & I.D. Number _____ Date/Time _____

TELEPHONIC (WITNESSED) ORAL CONSENT: Due to exigent medical circumstances and the current physical unavailability of this incapacitated patient's authorized representative, we the undersigned clinician and witness have obtained oral informed consent from _____ (Name of patient's authorized representative), who bears the following relationship to the patient: _____.

Physician's Signature & I.D. Number _____ Date/Time _____

Witness (sign and print, include title) _____ Interpreter's Signature & I.D. Number _____ Date/Time _____

Jackson Health System is operated by the Public Health Trust of Miami-Dade County (the Public Health Trust), an agency and instrumentality of Miami-Dade County Florida. The University of Miami, a Florida not-for-profit corporation, has entered into a written agreement with the Public Health Trust. According to Section 768.28, Florida Statutes, the University of Miami, its Miller School of Medicine, and its employees and agents, are acting as agents of the Public Health Trust while providing patient services within the Jackson Health System, pursuant to that agreement. The exclusive remedy for injury or damage suffered as a result of any act or omission of the agents of the Public Health Trust, while acting within the scope of duties, pursuant to the

[redacted]