VIDANT HEALTH

AUTHORIZATION & CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS

"I," "me," or "my" refers to the patient named below, and where appropriate, refers to the person(s) with the legal right to consent for the patient. "Vidant Health/ECU Physicians" refers to the particular Vidant Health affiliated hospital, clinic, or other service and ECU Physicians to which I have been accepted as a patient, as indicated above. "Medical Staff Members" refers to all physicians and advanced practice professionals who provide medical treatment and surgical services at Vidant Health/ECU Physicians.

AUTHORIZATION FOR TREATMENT: I understand that there are routine diagnostic and therapeutic examinations and procedures that are ordinarily associated with being a patient at Vidant Health/ECU Physicians ("Medical Treatment"). I understand that Medical Staff Members, clinical staff, agents, and personnel will direct my Medical Treatment as necessary for my health benefit according to their professional judgment. I hereby voluntarily request, authorize, and consent to such Medical Treatment. I understand that if more invasive or non-routine procedures or examinations are necessary, I will be informed of the risks and benefits of such necessary additional treatment and will be given the opportunity to consent to each such necessary additional treatment. I understand that the practice of medicine and surgery is not an exact science and that no guarantees have been made as to the results of medical care, treatment, or examination rendered by Vidant Health/ECU Physicians.

PHYSICIANS AS INDEPENDENT CONTRACTORS: I understand that some Medical Staff Members (such as radiologists, pathologists, emergency services physicians, anesthesiologists, etc.) are independent contractors and are not employees or agents of Vidant Health/ECU Physicians.

RELEASE OF INFORMATION: The undersigned authorizes Vidant Health/ECU Physicians to disclose all or any parts of the patient's medical record to any of the following: listed insurance companies, government agencies, the patient's employer or any agency conducting reviews concerning worker's compensation case, any review agency which conducts reviews of hospital utilization under an agreement with the patient's employer or other payment source, and any health care organization, healthcare provider or agency needing medical information to assist in the patient's continuing care. The disclosed medical record may include information regarding the treatment of psychiatric and drug and alcohol abuse conditions, information concerning AIDS, AIDS-related conditions or HIV status. I also understand that I may revoke this authorization by providing written notice to the hospital.

MEDICARE/TRICARE, MEDICAID PATIENT'S INFORMATION: I certify that the information I have given in applying for payment under Title V, XVII, and XIX of the Social Security Act is complete and correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare/Medicaid Claim. I authorize Vidant Health/ECU Physicians and the applicable County Department of Social Services to discuss information about me in the event I apply for financial assistance, including Medicaid. This information includes the following: date of application, application status, the reason my application remains pending, any verification required to complete my application, the date and reason of denial (if applicable). I received the document titled "An Important Message from TRICARE" or "Medicare" at the time of my admission. My signature only acknowledges that I received this message from Vidant Health/ECU Physicians and does not waive any of my rights to request a review or make me liable for any payment.

ASSIGNMENT OF INSURANCE/LIABILITY BENEFITS: I hereby authorize payment directly to Vidant Health/ECU Physicians and Medical Staff Members involved in my treatment or diagnosis at Vidant Health/ECU Physicians by the group insurance, major medical insurance, hospital, surgical, medical, and any other insurance payable to or on behalf of the undersigned, by virtue of hospitalization or Outpatient Services of the below named patient. I unconditionally assign any insurance benefits to Vidant Health/ECU Physicians and Medical Staff Members involved in my treatment and further authorize both to apply any surplus insurance benefits or any other payments received from any source, to the payment of other unpaid bills of the below named patient or of the undersigned or any individual who is financially responsible for the patient or guarantor. I understand that I am financially responsible to the Hospital and physicians for charges not paid by insurance. If an unpaid balance is sent to a collection agency, I will be responsible for any legal fees and/or interest associated with collection of debt. Vidant Health/ECU Physicians will make every effort to pre-certify and/or pre-authorize treatment with third party payors who conduct Utilization Review as a service to patients; however, Vidant Health/ECU Physicians does not accept responsibility for lack of pre-certification and/or preauthorization and is not responsible for the final payment outcomes or timing restraints I irrevocably assign to Facility and/or Medical Staff physicians all rights, title and interest in and to any third party liability arising out of injuries sustained by me necessitating the services provided, up to the amount necessary to discharge the debt due Facility and/or Medical Staff physicians. I authorize and direct any person or corporation having notice of this assignment to pay directly to Facility and/or Medical Staff physicians all medical, liability or other insurance or third-party benefits to which I am or may be entitled related to my care up to the amount necessary to discharge my indebtedness to Facility and/or Medical Staff physicians. I hereby appoint Facility, Medical Staff physicians and any agent acting on their behalf as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer or third party liability carrier of any and all benefits due me for the payment of charges associated with my treatment. If any part of this assignment is void as against public policy or in violation of any statute or law of the State of North Carolina, I intend that all other provisions of this assignment remain enforceable.

PERSONAL VALUABLES: If admitted as an inpatient, I hereby release the hospital from any responsibility for valuables, money, personal or other possessions that are not deposited with the hospital for safekeeping.

NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of the Notice of Privacy Practices ("NPP") in effect for Vidant Health/ECU Physicians. The Notice of Privacy Practices is a complete description of my privacy rights as a patient of Vidant Health/ECU Physicians.

MEDICAL DEVICES TRACKING PROCESS: Medical device tracking regulations published under the Federal Food, Drug, and Cosmetic Act, as amended, went into effect in August of 1993 to ensure that patients who receive certain medical devices can be notified if problems occur with such devices. In the event that I receive one of the devices which the FDA has labeled for tracking, I agree that Facility has the right to report any and all information in its possession which will assist the FDA in tracking the device, including, but not limited to medical information, name, telephone number, address, and social security number. In the event that I do not agree to this provision, it shall be deemed that I have refused to allow the medical device to be tracked and reported to the FDA.

[redacted]

[redacted] (73 yrs) Female

[redacted] ADMIT: 1/1/2018 1313 E

Please check the box to the left of the appropriate Vidant Health location:

☐ East Carolina Endoscopy Center	☒ Vidant Bertie Hospital	☐ Vidant Home Health & Hospice	☐ Vidant SurgiCenter
☐ Leo W. Jenkins Cancer Center	☐ Vidant Chowan Hospital	☐ Vidant Medical Center	☐ Other _____
☐ The Outer Banks Hospital	☐ Vidant Duplin Hospital	☐ Vidant Medical Group	
☐ Vidant Beaufort Hospital	☐ Vidant Edgecombe Hospital	☐ Vidant Roanoke-Chowan Hospital	

VIDANT HEALTH

RELIGIOUS INFORMATION (IF ADMITTED TO THE HOSPITAL): For a person admitted to the hospital, Vidant Health may provide a patient list for community clergy when they request it. This list includes the name and location of the patient, the patient's general condition, and the patient's religious affiliation. If you prefer to have your information removed from this list, please initial here _____.

TEXT MESSAGING: By signing this consent form, I authorize Vidant Health, through its vendor texting service, to contact me by SMS text message to serve me better. Texting may include timely reminders about needed doctor visits or Mychart information. If you do not want to get these text messages, please initial here _____.

WIRELESS TELEPHONE NUMBER: Vidant Health, medical staff members, clinical staff, agents, and personnel may contact me by telephone at any number contained in my records, including wireless telephone numbers, for the purpose of servicing my account and collecting amount due. Methods of contact may include pre-recorded or artificial voice messages and the use of automatic dialing services. If you do not want to receive communication through your wireless telephone, please initial here _____.

PHOTOGRAPHS/VIDEO: I give permission to Vidant Health and Medical Staff Members (including agents and contractors) to take photographs or make videos or drawing of me for permissible treatment, payment, or health care operations purposes (may include quality assessment, patient identity, education, and training) as long as consistent with policies and laws that protect my rights. If you do not want to participate in photographs/videos/drawings, please initial:

Photograph _____ Video _____ Drawings _____

DO NOT BILL INSURANCE: I understand that if I have paid entirely out-of-pocket (pay on my own without any insurance) for this medical visit that I may ask not to share related information about the visit with my health insurer by completing a Patient Request for Restriction form. By initialing below, I am asking Vidant Health not to share information about my visit with my health insurer, and that I am agreeing that I will pay all expenses related to this visit within fifteen (15) days of discharge. I understand and agree that if I fail to pay all related charges within 15 days, that Vidant Health may share my information with my health insurer. If you agree to the above and do not wish to bill your insurance, please initial here_____.

DO NOT SURVEY: I understand that as a part of the Vidant Health's performance improvement activities, a survey vendor may contact me to ask about my experience, at which time I may decline to answer questions. If you do not want to be contacted by the survey vendor, please initial here _____.

HEALTH INFORMATION EXCHANGE: Vidant Health/Medical Staff Members uses an electronic Health Information Exchange (HIE). This exchange provides a fast, secure, and reliable way to provide health information to providers. I understand my electronic health records may be shared with other providers who are involved in my care. I understand a provider may request and receive my health information using other methods permitted by law, such as fax or mail. If you do not want your electronic health information shared electronically, please initial here _____.

I have read this information and received a copy. I understand the information. I am the patient or I am authorized to act on behalf of the patient, and to sign this document verifying my authorization/consent to the above stated information and terms. I understand that I may revoke this Authorization/Consent by providing written notice to Vidant Health, except to the extent actions taken in reliance on this Authorization/Consent. This Authorization/Consent is effective one year from date signed; however, will not expire for service or claims processing for admissions or visits occurring while it was in effect.

Note: If the services provided are recurrent therapeutic series (rehab/chemo), you will only need to sign one consent form to cover all the recurrent services provided within 90 days from the date of your signature.

Patient:

Signature of Patient	Date	Time

Print Name of Patient

Representative:

Signature of person signing on behalf of Patient	Date	Time
[redacted] (spouse)	1-1-18	1:35PM

Print Name of person signing on behalf of Patient	State why patient can not sign for him/herself

Guarantor: (person or entity that agrees to be responsible for payment) By signing below as guarantor [does not apply to the patient, spouse (when medical care is necessary), or parents of a minor child], I hereby agree to pay all charges of Facility that are not covered or paid within a reasonable time by any medical insurance/coverage, whether or not I am otherwise legally obligated to pay.

Signature of Guarantor	Print name of Guarantor		

Witness:

Signature of Witness	Date	Time
[redacted]	1-1-18	1:35PM

[redacted] (73 yrs) Female

Lowry, Brian Patrick, Md

ADMIT: 1/1/2018 1313 E