CONSENT FOR TREATMENT

I have a condition requiring emergency, inpatient or outpatient health care, and I voluntarily consent to such care, including diagnostic procedures, laboratory testing, toxicology screening and medical treatment by my physician and hospital personnel. I acknowledge that no guarantees have been made to me as a result of such care.

HIV, SYPHILIS, HEPATITIS TESTING

I understand that Virginia Code § 32.1-45.1 provides that in the event of any health care provider's exposure to my blood and/or body fluids, I shall be deemed to have consented to laboratory testing for human immunodeficiency virus (HIV) or hepatitis B or C viruses, with release of the test results to the person(s) exposed.

RESPONSIBILITY FOR VALUABLES

I waive any cause of action that I now have or may have in the future against Bon Secours Health System, Inc., their officers, agents or employees arising from the loss of or damage to any personal property.

ASSIGNMENT OF INSURANCE BENEFITS/FINANCIAL AGREEMENT

I assign and direct all insurance benefits available to me, be paid directly to the hospital and hospital-based physicians, and agree to be financially responsible for any required co-payments or deductibles and all other charges not covered by my insurance plan. I understand that financial assistance applications are available to me should I be uninsured or otherwise anticipate difficulty concerning payment of all or part of my bill for health care services rendered by Bon Secours Health System Inc., their hospitals and hospital-based physicians. I understand that I am responsible for any services not covered by my insurance benefits as well as any unpaid balance plus the reasonable costs of collections, including any attorney fees or court costs associated with attempts to collect the unpaid portion of my bill.

RECORDKEEPING

I understand that medical records will be retained for five years after the date of the last visit or for five years following a patient's death. In the case of a minor, the medical record will be retained for 10 years after the last visit or for five years after age 18, whichever comes later.

CONSENT TO PHOTOGRAPHY FOR IDENTIFICATION PURPOSES

I hereby consent to have my photograph taken at any Bon Secours Health System Inc. affiliated hospital. I understand that the images from such photography will be included in my electronic medical record and are considered Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such images will be used for identification purposes only. The images will not be further used or disclosed without my written authorization except as may be required by law.

CONSENT TO RECEIVE TELEPHONE CALLS

PLEASE CAREFULLY READ THE FOLLOWING INFORMATION ABOUT HOW WE MAY USE YOUR PHONE NUMBER(S). IT AFFECTS YOUR LEGAL RIGHTS.

CONSENT

I hereby consent Bon Secours Health System, Inc., including its employees, agents, assigns, affiliates, or independent contractors (including but not limited to debt collection agencies), to contact me by voice call, at the phone number(s) associated with my account. I understand that by giving this consent, BSHSI may contact me about any and all matters related to me, my medical care, my account, appointments, billing issues, and the repayment or collection of amounts due. I understand that these calls may be placed using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the phone number(s)provided are for a cellular telephone or other service that charges me in any way for calls or messages received (for example, per minute, per message, per unit of data received or otherwise), I am solely responsible for any charges incurred under my agreement with my cellular telephone or other service provider.

RELEASE

In consideration for BSHSI's provision of products and/or services and my request to receive calls or messages at the phone number(s) provided, I hereby release BSHSI from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

Financial Agreements / Assignment of Benefits / Authorized Representative / Agent

1. I assign Bon Secours Health System, Inc., all rights to benefits, insurance payments, insurance reimbursements or other payments or judgements to which I may be entitled for services provided to me at Bon Secours facilities. I authorize Bon Secours to bill my insurance and assign the payment of these benefits directly to Bon Secours Health System, Inc.
2. I assign all rights to benefits, insurance payments, insurance reimbursements or other payments or judgments to which I may be entitled for hospital-based physician services (pathology, radiology, cardiology, etc.) and/or emergency department services to the physician or organization providing the professional service. I also authorize submission of a bill for professional services to my insurance for payment.
3. I authorize and designate Bon Secours Health System, Inc., as my authorized agent and representative with the power to act on my behalf with respect to all matters related to all of my rights, benefits, privileges, protections, claims, causes of action, interests or

recovery arising out of any coverage source, including but not limited to the ability to request reconsideration and/or appeal payment decisions made by any group health plan, employee benefits plan, health insurance plan , any other insurance plan or utilization review entity for coverage or grievance review (the "plan"). This includes, without limitation, the authority and right to: file medical claims with the plan; file appeals and grievances with the plan; request verification of coverage or pre-certification or authorization; file pre-service and post-service claims; request any and all information and documents under which the plan is established or operated; request any and all policies, procedures and guidelines and protocols considered by the plan in connection with the benefit claim determination; and to institute any litigation and/or complaints against the plan naming me as the plaintiff in such litigation if necessary.

4. I designate, authorize and convey to Bon Secours Health System, Inc., to the fullest extent permissible under law under any applicable plan the right and ability to act as my Authorized Representative with respect to benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.503-1(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Mercy Health. This includes, without limitation, the right and ability to act on my behalf in connection with any claim, appeal right, cause of action, including without limitation, any claim that may be brought pursuant to ERISA, that I may have under the plan; and the right and ability to act on my behalf in connection with any claim, right, or cause of action including litigation against the plan (even to name me as a plaintiff in such action) that I may have under such plan, I understand I can revoke this authorization in writing at any time.

Language Interpreters

Mercy Health provides free aids and services to people with disabilities to communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats)

You can contact the person at the registration desk to receive information on how to obtain the free aids and services for persons with disabilities or access the interpretation services.

All patients have access to interpretation services 24/7 at no personal cost to them.

I HAVE READ THE ABOVE AND ALL MY QUESTIONS HAVE BEEN ANSWERED
I have received information on the following topics: Conditions of Admission/Registration, Good Help Commitment, Sign Language, Patient Rights and Responsibilities, Pain Control, Virginia Prescription Drug Monitoring Program, Advance Directives, Tobacco-Free Campus, How You Can Prevent A Fall, How You Can Prevent Medical Errors, CarePages.com, Discharge Instructions, and Billing Information.

I certify that I have read and received a copy of the foregoing information and certify that I am the patient or person duly authorized by the patient or Virginia law to execute this Conditions of Admission/Registration and accept its terms.

Signed (patient or patient representative) Collect sign3 Signature	Relationship to Patient Collect sign4 Signature
Initials:	Patient unable to sign reason

Collect ini1 Signature	Collect sign5 Signature

PHARMACY LIMITED POWER OF ATTORNEY
If you cannot afford your medication, or if your medication is not covered by your insurance plan, Bon Secours Health System Inc. may be able to obtain reimbursement for some of your medications through Patient Assistance Programs sponsored by drug manufacturers. To qualify for these programs, it may be necessary to provide information regarding your financial status, illness, and/or treatment to the drug manufacturer sponsoring the program(s). All information associated with the patient assistance programs will remain confidential and will only be provided to drug manufacturers in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state law.

My signature on this form authorizes Bon Secours Health System Inc., their hospitals, and hospital personnel to complete any necessary application forms. I release any claim to the medication I may receive as a result of my participation in the patient assistance programs and give my permission for any medication to be repackaged. This authorization shall remain in full force from the date signed until I cancel it or no longer belong to the patient assistance programs.

Collect signature1 Signature Signature of patient	Collect signature2 Signature Signature of patient representative