Conditions of Admission/Registration

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.

RELEASE AND RESPONSIBILITY FOR VALUABLES

The hospital provides a designated secure area. The undersigned acknowledges that the patient has been given an opportunity to place any such belongings in the safe and therefore agrees that the hospital shall not be liable for loss of or damage to any such belongings unless deposited with the hospital for placement in the safe at the time of admission.

I understand the hospital cannot protect personal possessions that are not placed in the designated secure area. I waive any cause of action that I now have or may have in the future against Bon Secours Richmond Health System and Bon Secours Hampton Roads Health System, their officers, agents or employees arising from the loss of or damage to any personal property that I fail to place in the designated secure area. Such items may include but are not limited to jewelry, hearing aids, eyeglasses, and dentures and other dental work.

RELEASE OF INFORMATION

I authorize Bon Secours Richmond Health System and Bon Secours Hampton Roads Health System, their hospitals and hospital personnel to release information from my medical record and billing records to (A) any third-party payor or insurance company responsible, in whole or in part, for paying my hospital bill for the purpose of benefit determination and claims review; (B) any independent auditors or reviewers retained by any third-party payor or insurance company providing health insurance benefits to me; (C) any third-party vendors or agents retained by the hospital for the purposes or processing of or otherwise obtaining payment for my hospital bill; (D) any third-party agents retained by the hospital to facilitate applications for financial assistance or other determination of my eligibility for Medicaid and other benefits to which I may be entitled; (E) any health care facility or physician to which I am transferred or referred to permit continuity of care; (F) any agency associated with medical device reporting as required pursuant to the Safe Medical Devices Act of 1990 (SMDA); and (F) anonymously, any medical research program operating pursuant to a research protocol approved by an authorized institutional review board (IRB).

As permitted or required by applicable state and federal laws, the information in my medical record that may be released to the entities listed above includes but is not limited to: (1) information about my medical condition and my treatment; (2) information about serious communicable diseases and infections, including information about sexually transmitted diseases, tuberculosis, hepatitis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and any other disease or medical condition for which mandatory reporting is required; (3) results of toxicology screening and information regarding treatment for substance abuse; (4) mental health, psychological and social information, including communications made to or from me by a psychiatrist, licensed clinical psychologist, licensed nurse practitioner, licensed physician's assistant and/or licensed social worker; (5) information related to my insurance plan, policy number and insurance coverage available to me; and (6) personal information about me, such as my address, telephone

number and Social Security number. This authorization is effective only as long as necessary to accomplish the purpose for which it is given. I understand that I may revoke this authorization in writing at any time, and I release from liability any hospital or health care provider that has acted in reliance upon it.

ASSIGNMENT OF INSURANCE BENEFITS/FINANCIAL AGREEMENT

I assign and direct all insurance benefits available to me, including to 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 authorize Bon Secours Richmond Health System and Bon Secours Hampton Roads Health System, their hospitals and hospital-based physicians to release records as necessary to support a claim for payment of charges associated with my health care by Medicare, Medicaid or other health insurance providers. 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 Richmond Health System and Bon Secours Hampton Roads Health System, their hospitals and hospital-based physicians. I understand that I am responsible for any Non Covered Services 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.

TELEMEDICINE

I hereby authorize the hospital to use telemedicine, which is defined as health care services (including delivery diagnosis, consultation, treatment, transfer of medical data and education) provided using "real time" or near "real time" audio, video or data communications, in the course of my diagnosis, treatment and care while a patient at the hospital. I understand that telemedicine involves the communication of my medical information, both orally and visually, to physicians and other health care practitioners at locations other than the hospital. I understand that if I receive telemedicine services, my health care provider will not be in the same room with me.

- I understand that I have the option to withhold or withdraw my consent to telemedicine at any time without affecting any right to future care or treatment and without risking the loss of my program benefits.
- I understand the potential benefits of telemedicine include but are not limited to:
  — Providing an efficient consultation with a specialist for medical evaluation and management.
- I understand the potential risks and consequences of telemedicine may include but are not limited to:
  — Such rare cases when transmitted information may not be sufficient (e.g., poor resolution of images) to effectively utilize telemedicine. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
- I understand that all laws applicable to the care I receive generally, including laws about the confidentiality of medical information and patient access to medical information and copies of medical records, apply to any telemedicine services provided to me at the hospital.

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 Bon Secours Health System Inc. affiliated hospitals and clinics. 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 (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, Texts, and Emails

PLEASE CAREFULLY READ THE FOLLOWING INFORMATION ABOUT HOW WE MAY USE YOUR ACCOUNT CONTACT TELEPHONE NUMBER(S) AND EMAIL ADDRESS (ES). IT AFFECTS YOUR LEGAL RIGHTS.

CONSENT

I hereby consent to Bon Secours Health System, Inc., including its employees, agents, assigns, affiliates, or independent contractors (including but not limited to debt collection agencies) (collectively "BSHSI"), contacting me by voice call, text message and email at the Account Contact Telephone Number(s) and Email Address(es) reflected on my account. I understand that, by giving this consent, BSHSI may contact me about any and all matters related to me, my medical care, or my account, such as appointments, the results of any tests or procedures, billing issues, the repayment or collection of amounts due, and offers of products or services available from BSHSI and that these calls may be placed using automatic dialers or pre-recorded voice messages. I further understand and agree that, if the Account Contact Telephone Number(s) or Email Address(es) 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 BSHI's provision of products and/or services and my request to receive calls or messages at the Account Telephone Number(s) and Email Address(es) 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).

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, Billing Information, Notice of Privacy Practices.

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 or registration & notification of Privacy and accept its terms.

Signed (patient or person authorized to consent for patient): ______________________________________
Relationship to patient: ______________________________ Date: ________________ Time: __________
Patient unable to sign. Reason: ____ Initials: __________

BON SECOURS VIRGINIA HEALTH SYSTEM
Bon Secours Health System, Inc.