Superior Family Medical Center

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September 21, 2020

Dear Parents:

The influenza season is upon us. The Centers for Disease Control or CDC has recommended that everyone six months and older get the influenza vaccine. Getting your child the flu shot is an easy, safe, and effective way to keep them healthy. This winter will be even more challenging as we face the COVID-19 pandemic with symptoms that overlap the flu infection. Vaccinations cut down on the number of days students are absent from school and decreases the general spread of the flu in the population at large. Our goal is to immunize as many students as possible, thereby decreasing the general spread of influenza throughout our community. Anyone with recurrent respiratory illness, asthma, or lung disease should definitely be vaccinated.

The cost of the influenza vaccine is $25 plus the cost of administration and will be billed to your health insurance, as most plans cover the influenza vaccination as part of their wellness plan. We ask that you please provide us with your insurance information on the back of this page and return it with your child. Attached to the letter you will find a "Consent to Treat" form that will need to be signed for <u>each</u> child receiving the vaccination and also returned with your child receiving the vaccination on October 7, 2020. If you do not have insurance coverage, Superior Family Medical Center and Brodstone Memorial Hospital will be providing this vaccination at no cost to you.

NOTE: Anyone allergic to eggs or anyone that has had an anaphylactic hypersensitivity reaction to eggs should receive the vaccination in their provider's office where they can be properly monitored and <u>not</u> at the school. Anyone with a fever or current illness should not be vaccinated until their symptoms have subsided. Common side effects include soreness at the vaccination site for up to two days (this usually occurs in one-third of those vaccinated), mild fever, fatigue, and/or muscle soreness which may persist for one to do days and happens infrequently.

Sincerely,

Timothy Blecha, M.D.

Robert Leibel, M.D.

Julie Theis, M.D.

Jason Hass, PA-C

Alisha Fangmeyer, APRN

Matthew Gatlin, PAC

Name of Student or Faculty Member: _____

Insurance Company Name: _____ Policy Number: _____

Policy Holder or Subscriber: _____ Group Number: _____

CONDITIONS FOR AND CONSENT TO TREATMENT AT
BRODSTONE MEMORIAL HOSPITAL/SFMC AND/OR SATELLITE CLINICS
(HEREIN AFTER "FACILITY")

1. Consent for Treatment I, (or the undersigned acting on behalf of the patient, understand that it is the responsibility of my/the patient's attending physician to obtain my/the patient's informed consent, when required, for medical treatment, special diagnostic or therapeutic procedures, or rehabilitation services rendered under the general and special instructions of my/the patient's attending physician.

   I, (or the undersigned acting on behalf of the patient), knowing that I (or the patient) have a condition requiring medical treatment, having been informed by my/the patient's attending physician of and understanding the nature and purpose of the procedures to be performed at Facility for my/the patient's condition the risks involved with the procedures, the alternatives to the prescribed rehabilitation as well as the consequences of not receiving treatment, hereby voluntarily consent to and authorize all medical, diagnostic and laboratory procedures as may be performed or prescribed by my/the patient's physician, or any person (including other physicians he/she may consult or engage, assistants, and other personnel, not limited to but including all staff of Facility) whom he/she may designate during my/the patient's treatment Facility.

   I understand that a test for the presence of the human immunodeficiency virus (HIV) may be performed under this general conditions of admission when deemed appropriate by my health care provider, without my signing an additional consent for the specific purpose of HIV testing. HIV is the virus which causes HIV infection that can eventually lead to Acquired Immunodeficiency Syndrome (AIDS). A person develops AIDS when the immune system becomes so damaged that it can no longer fight off disease and infection. Tests are available to determine the presence of HIV antibodies in the blood. A negative test result shows that HIV antibodies were not found in the blood. It does not mean that a person is free of HIV infection because more time may be needed for the immune system to make antibodies. A positive HIV antibody test indicates a previous exposure to the virus and that you have HIV antibodies in your blood and can infect someone else through sexual contact, sharing needles or syringes, or from mother to baby during pregnancy. The test cannot tell you if you will eventually develop signs of illness related to HIV, or if you do, how serious that illness might be.

   I, (or the undersigned acting on behalf of the patient), acknowledge that no guarantees have been made to me as a result of diagnosis, treatment, test or examinations at Facility.

2. Legal Relationship Between Hospital and Physician – Physicians providing services to the patient while at Facility may be independent contractors with the patient and are not the employees or agents of Facility. These independent contractors will submit a separate bill for their professional services. The patient is under the care and supervision of his/her attending physician and it is the responsibility of Facility and its staff to carry out the instructions of that physician.

3. Release of Information – I hereby authorize Facility to release any and all of my/the patient's medical records, verbally, via facsimile, via photocopying, or via on site review to other health care institutions to whose care I may be transferred, or am being evaluated for transfer to, and agencies or physicians that may become involved in further treatment or follow-up care, to my/the patient's insurance company or third party payor, for utilization review purposes and for the purpose of processing my/the patient's claim and obtaining payment of the account to Facility. I authorize the facility to release any information my records may contain regarding the diagnosis or treatment of HIV (AIDS) or other sexually transmitted or communicable diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment to any hospital personnel rendering care to me or who may need to review my records for billing or quality control and peer review purposes and to other health care institutions to whose care I may be transferred, or am being evaluated for transfer to, and agencies or physicians that may become involved in further treatment or follow-up care. I also authorize Facility release my/the patient's general status information to relatives and friends, and obtain my drug history per electronic prescription system.

4. Medicare/Medicaid Authorization – I, whether signing as patient or agent, hereby authorize Facility to release to Medicare and/or Medicaid to the Social Security Administration and/or its intermediaries or carriers, to any peer review organization, or any state agency which I/the patient am entitled to payment for medical benefits any information needed for this or a related Medicare and/or Medicaid claim. I certify that the information given by me in applying for payment under Title XVIII and Title XIX of the Social Security Act is correct.

5. Assignment of Benefits and Authorization to Bill – I, whether signing as patient or agent, authorize billing by and direct payment Facility of any insurance benefits (as defined below) and any governmental program benefits otherwise payable to or on behalf of me or the patient for the rehabilitation services, including emergency services if rendered, at a rate not to exceed Facility's regular charges. The term "insurance benefits" as used herein includes all insurance benefits including but not limited to health insurance, accident, casualty insurance, medical payments coverage and uninsured or underinsured insurance. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment. In consideration of goods and services provided, the undersigned gives Facility an irrevocable assignment to any and all rights, title and interest he/she has in all insurance benefits or governmental program benefits payable to him/her or on his/her behalf for services provided by Facility, its employees and others working under an arrangement with Facility. I direct all insurance companies, health plans, governmental agencies and their agents or contractors, and attorneys to make such payment directly to Facility.

6. Personal Valuables – I understand that Facility shall not be liable for any money, jewelry, documents, clothing or other personal property, which is lost, damaged or stolen that I or the patient, or anyone accompanying the patient possess during treatment unless deposited in the facility's place of safe keeping. Facility shall not be liable beyond an amount of $50.00 for any loss or damage to any valuable deposited in the place as safekeeping. Money or valuables not retrieved from the place of safe keeping within two (2) years of deposit will be disposed of according to law.

7. Self Determination – Facility respects the rights of the patient and recognizes the individual needs of each patient to make informed decisions regarding his or her medical care. The Facility policy complies with the Patient Self Determination Act and will facilitate the process for the patient to express his/hers preferences regarding treatment. The Facility intends to assure that decision making regarding treatment options is done in keeping with ethical, legal and clinical standards. I acknowledge that I was provided a copy of Patient Rights.

8. Guarantee of Payment – For good and valuable consideration of services to be rendered to me/the patient identified on the face of this sheet. I hereby guarantee payment of the entire medical bill expense incurred at Facility. The Hospital and Clinic will provide medical services to patients who have limited or no financial means. The patient accounts and financial services staff will work with patients to find a payment solution when necessary.

9. Cellular Phone, Text and Email Contact Policy – By providing us with an email address or telephone number for a cellular phone or other wireless device, you are expressly consenting to receiving communications – including but not limited to prerecorded or artificial voice message calls, text messages, emails and calls made by an automatic telephone dialing system – from us and our affiliates and agents at that number.

NOTICE TO ALL PATIENTS:

A doctor of medicine or doctor of osteopathy is not present in our facility 24 hours a day, seven days a week. To meet the needs of our patients that develop an emergency medical condition during this time, the on-call provider will be asked to come and evaluate such patient. Until the arrival of the on-call provider, the emergent condition will be assessed and treated by other qualified personnel within the facility.

Do you have an Advance Directive? ☐YES ☐NO ☐Unknown ☐Information Provided

MY SIGNATURE BELOW INDICATES THAT THIS INFORMATION HAS BEEN EXPLAINED TO ME; I HAVE READ THIS FORM OR IT HAS BEEN READ TO ME; I UNDERSTAND THIS AGREEMENT FULLY.

_____ _____

Signature of Patient or Representative Date

_____ _____

If other than patient, relationship to patient Reason if other than the patient (incompetent, minor, etc.)

_____

Witness