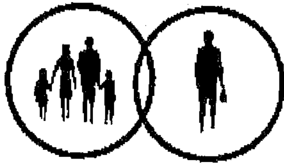
Superior Family Medical Center



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October 13, 2021

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 continue to 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 20, 2021. 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: ______________________ Date of Birth: __________

Address: ____

Insurance Company Name: ________________ Policy Number: ______________

Policy Holder or Subscriber: ________________ Group Number: ______________

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6. Personal Valuables: I understand that the Facility shall not be liable for any money, jewelry, documents, clothing or other personal property, which is lost, damaged or stolen that I, or anyone accompanying me, possess during treatment unless deposited in the Facility's place of safekeeping. The Facility shall not be liable beyond an amount of $50.00 for any loss or damage to any valuable deposited in the place of safekeeping. Money or valuables not retrieved from the place of safekeeping within two (2) years of deposit will be disposed of according to law.
7. Self Determination: The Facility respects the rights of the patient and recognizes the individual needs of each patient to make informed decisions regarding his/her medical care. The Facility policy complies with the Patient Self Determination Act and will facilitate the process for me to express my 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, I guarantee payment of the entire medical bill and any expenses incurred at the Facility. The Facility will provide medical services to patients who have limited or no financial means. When necessary, the patient accounts and financial services staff will work with patients to find a payment solution.
9. Cellular Phone, Text and Email Contact Policy: By providing the Facility with an email address or telephone number for a mobile 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.
10. Photographs and Videotaping: I understand that still or motion pictures may be taken to document my condition, for care, for patient identification, and/or for educational purposes. Closed circuit television monitoring and recording may be used at the Facility for general purposes, including care and security.

NOTICE TO ALL PATIENTS:

A doctor of medicine or doctor of osteopathy is not present at the Facility 24 hours a day, 7 days a week. To meet the needs of our patients who develop an emergency medical condition during this time, an on-call health care provider will be asked to come to the Facility and evaluate such patient. Until the arrival of the on-call health care 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

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

THE UNDERSIGNED CERTIFIES THAT HE/SHE IS THE PATIENT, PATIENT'S GUARDIAN, POWER OF ATTORNEY, PARENT, OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PARENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Patient_Signature DATE

Signature of Patient or Representative Date

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

Witness_Signature

Witness

Patient_Name Episode_Number
Admission_Datetime Patient_Class

CONDITIONS FOR AND CONSENT TO TREATMENT AT BRODSTONE MEMORIAL HOSPITAL, SUPERIOR FAMILY MEDICAL CENTER, AND/OR SATELLITE CLINICS (collectively the "FACILITY")

1. Consent for Treatment: I understand that it is the responsibility of my health care provider (hereinafter "Provider") to obtain my informed consent, when required, for medical treatment, special diagnostic or therapeutic procedures, or rehabilitation services rendered under the general and special instructions of my Provider.

   I, knowing that I have a condition requiring medical treatment and having been informed by my Provider of and understanding the nature and purpose of the procedures to be performed at the Facility for my condition, the risks involved with the procedures, the alternatives to the prescribed rehabilitation, and the consequences of not receiving treatment, voluntarily consent to and authorize all medical, diagnostic and laboratory procedures as may be performed or prescribed by my Provider or any persons (including other health care providers he/she may consult or engage, assistants, and other personnel, including but not limited to all staff of the Facility) whom he/she may designate during my treatment at the Facility.

   I understand that a test for the presence of the Human Immunodeficiency Virus (HIV) may be performed under this consent to treatment when deemed appropriate by my Provider, without my signing of 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 a person has HIV antibodies in their blood and can infect someone else through sexual contact, sharing needles or syringes, or from mother to baby during pregnancy. The test cannot tell a person if he/she will eventually develop signs of illness related to HIV, or if they do, how serious that illness might be.

   I acknowledge that no guarantees have been made to me as a result of diagnosis, treatment, test or examinations at the Facility.

   I acknowledge that telemedicine or other electronic technologies may be used to communicate between health care providers not physically present at the Facility.

2. Legal Relationship Between Facility and Health Care Providers: Health care providers providing services to the patient while at the Facility may be independent contractors and are not the employees or agents of the Facility. These independent contractors will submit a separate bill for their professional services. The patient is under the care and supervision of his/her Provider and it is the responsibility of the Facility and its staff to carry out the instructions of that Provider.
3. Release of Information: I authorize the Facility to release any and all of my medical records, verbally, via facsimile, via photocopying, via electronic transfer, or via on site review, to other health care institutions to whose care I may be transferred, or I am being evaluated for transfer to, and agencies or health care providers who may become involved in further treatment or follow-up care, to my insurance company or third party payor, for utilization review purposes, and for the purpose of processing my claim and obtaining payment of the account to this Facility. I authorize the Facility to release my records 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 Facility 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 I am being evaluated for transfer to, and agencies or health care providers who may become involved in further treatment or follow-up care. I also authorize the Facility to release my general status information to relatives and friends, and obtain my drug history per electronic prescription system.
4. Medicare/Medicaid Authorization: I authorize the Facility to release to Medicare, Medicaid, the Social Security Administration and/or its intermediaries or carriers, any peer review organization, or any state agency, which I 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 authorize billing by and direct payment by the Facility of any insurance benefits (as defined below) and any governmental program benefits otherwise payable to or on behalf of myself for the rehabilitation services, including emergency services if rendered, at a rate not to exceed the 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. I understand that I am financially responsible for any charges not covered by this assignment. In consideration of goods and services provided, I give the Facility an irrevocable assignment to any and all rights, title and interest I have in all insurance benefits or governmental program benefits payable to me or on my behalf for services provided by the Facility, its employees and others working under an arrangement with the Facility. I direct all insurance companies, health plans, governmental agencies and their agents or contractors, and attorneys to make such payment directly to the Facility.