



Consumer Access Welcome Packet

Thank you for choosing AdventHealth for your healthcare needs. This packet will include copies of the forms pertaining to your registration. Please use these forms as reference during the signature process.

Included in this packet:

Admission and Treatment Consent

Notice of Patient Privacy Practices

Patient Bill of Rights

Hospital Quality Measures and Patient Safety Information

Form No Surprises Act Model Disclosure Notice

Opioid Alternatives Flyer

Citizenship Status Acknowledgment

Advanced Directives

Health Equity Promise

Understanding Your Emergency Room Cost

Patient Name: _____

MRN: _____

Date of Birth: _____

ADVENTHEALTH TREATMENT AND CONSENT AGREEMENT

(Florida Minors Form Version 9.1)

AdventHealth operates facilities including, but not limited to, hospitals, outpatient centers, medical groups, and Centra Care locations (referred to all together in this document as “AdventHealth”) in Florida. Many of these facilities are separate legal entities. You may ask us for a list of AdventHealth entities. This AdventHealth Treatment and Consent Agreement (“Agreement”) must be signed by the Patient or by the Patient’s Legal Representative acting for the Patient (for example, a parent signing for their minor child). All references to “I”, “me”, “my”, “you” and “your” refer to the Patient.

CONSENT TO TREATMENT:

1. Services. I consent to receive and have arranged on my behalf diagnostic and treatment procedures, prescribed medications, examinations and laboratory procedures or inpatient admission or other items (“Services”) needed for my treatment during my admission to or treatment at AdventHealth by doctors (“Physicians”), and other medical professionals, residents, students, integrated physician networks, health plan networks, and AdventHealth employees, contractors, and personnel (collectively “Care Providers”). I understand I will be told about my treatment and will be able to ask questions about the risks, options and hoped for outcome of the treatment before I let the treatment be done. I agree that no promises have been given to me as to the outcome of any treatment.

2. Photography. I consent to photographs, video monitoring or audio recordings being taken of me for verifying my identity and/or my treatment.

3. Video Visits. If I want to schedule a Video Visit or if my Physician thinks a Video Visit will work best for my care, I consent to be treated through electronic communications online that will connect me with my Physician or Care Provider in another location. I understand that during a Video Visit there is a risk of technical failures beyond the control of AdventHealth which could make the images harder to see correctly, or cause my health record to be breached or not accessible, or delay my treatment. I also understand that a Video Visit may be more efficient and allows me to stay at home for treatment or be treated by a distant specialist. I understand that other persons may be present during the Video Visit.

4. Independent Contractors. I understand that many of the Physicians and Care Providers who provide treatment to me at a hospital, ambulatory surgery center, free standing emergency department or urgent care facility are not employees or agents of AdventHealth. I understand that these independent contractors may, as permitted by law, bill me on their own for the Services they provide. Independent contractors are responsible for their own actions. AdventHealth is not responsible for Services provided to me by these independent contractors. AdventHealth does not pay for the errors or mistakes or failure to act by any of these independent contractors.

5. Patient Rights. I understand a copy of AdventHealth’s Patient Rights and Responsibilities information will be offered to me as required by law.

6. Advance Directives. I have been able to tell AdventHealth about my current choices for Advance Directives by filling out a new form or giving them a copy of my earlier Advance Directives. AdventHealth,

Physicians and Care Providers are not required to follow Advance Directives they do not know about. Please select which option(s) below applies to you:

- ☐ I am under 18 years of age and have no Advance Directives.
- ☐ I have Advance Directives and I have given a copy to AdventHealth.
- ☐ I have Advance Directives, but I have not given AdventHealth a copy. I understand I must give AdventHealth a copy.
- ☐ I do not have Advance Directives.
- ☐ I would like information about Advance Directives.

7. Legal Representative. I have been able to tell AdventHealth about my current choice for my Legal Representative by giving them a copy of my legal documents outlining my decision. AdventHealth, Physicians and Care Providers are not required to involve my Legal Representative in my treatment if they do not know who my Legal Representative is or if there are changes to this delegation they do not know about. I understand that I am responsible to tell AdventHealth, Physicians and Care Providers when I change my Legal Representative, or when the powers of the Legal Representative end.

8. Personal Property/Valuables. Where applicable, I will give any personal property or valuables to AdventHealth for storage in a secure location if I want to ensure my personal property and valuables are safe. AdventHealth shall not be liable in any event for loss or damage to personal property or valuables in excess of \$100. I release AdventHealth from liability for any personal property or valuables that are not given to AdventHealth for safekeeping.

CONSENT TO PAYMENT:

1. Payment. I, or (where permitted by law) my Legal Representative signing this Agreement for me, must pay for the Services received during my treatment today and any related future Services provided by AdventHealth, Physicians and Care Providers ("Account"), including any required co-pays, with cash, check, credit card and/or insurance. I understand that no credit is being given to me and that the Account is due and payable right away. **If I cannot pay my Account in full when due, AdventHealth's Financial Services Office will determine if I qualify for any financial assistance.** If I do not pay for all my Services and AdventHealth sends my Account to an attorney or collection agency, I agree to pay the attorneys' fees and collection expenses as permitted by law up to 25% of the money I owe.

2. Credit Card Payments. If I pay for the Services with my credit card, I certify that I am the credit card holder and authorize payment of the Services.

3. Insurance Payments and Assignment of Benefits. If I am entitled to benefits under: (i) the Medicare program, the Medicaid program, other kinds of government insurance (the "Program"); (ii) Employee Retirement Income Security Act ("ERISA") health benefit plans; or (iii) any insurance policy or other health benefit plan (covering me or anyone legally responsible for me) or from any other source (the "Benefit Plan"), including as a result of injuries sustained by me, in consideration for admission to and/or for Services provided to me by AdventHealth, Physicians and Care Providers, which includes independent contractors, I irrevocably assign, transfer and convey the Program and Benefit Plan benefits payable and all right, title and interest in and to such benefits, compensation or payment received or to be received for the Services provided to me by AdventHealth, Physicians and Care Providers (collectively "Benefits") to AdventHealth, Physicians, Care Providers, and their assignees. I irrevocably authorize payment of my Benefits directly to AdventHealth, Physicians, Care Providers and their assignees, to be applied to my Account. I understand that assigning my payment of Benefits will not relieve me of obligations to pay AdventHealth, Physicians, Care Providers, and their assignees, for charges that

are not covered by this assignment. If assignment or direct payment is not permitted, I agree to direct my Benefit Plan to make checks or drafts jointly payable to (i) the beneficiary or covered person and (ii) AdventHealth, Physicians, Care Providers, or their assignees, and to send payment to me in care of AdventHealth, Physicians, Care Providers, or their assignees. I also give permission for AdventHealth, Physicians and Care Providers to seek payment in full for charges from parties who injure me or others who may be obligated to pay for my care and their insurers even if Benefits are payable by a managed care payer on my behalf. I agree to pay the difference between the amount my insurance pays and AdventHealth, Physicians or Care Providers' charges (as limited by law or contract) except when AdventHealth, Physicians or Care Providers have a contract(s) with a Benefit Plan that will not let them collect that difference from me and/or the subscriber.

If my Benefit Plan includes a self-funded/insured plan under ERISA or other type of Benefit Plan, in order to help me get my Benefits: I irrevocably authorize and appoint AdventHealth, Physicians, Care Providers or their assignees to be my representative and attorney-in-fact, when AdventHealth, Physicians, Care Providers or their assignees agree in writing to so act in taking all actions needed to get payment, appealing any adverse benefit determination or requesting any reconsideration and to receive notices on my behalf for this purpose. I will follow the procedures required by ERISA or my Benefit Plan for this authorization, if any.

4. Honesty and Cooperation Statement. I promise that my (i) payment sources and insurance coverage information and (ii) any completed insurance applications are true and correct to the best of my knowledge. I agree to give my insurance or financial assistance information timely. I agree to pay all charges that could have been filed if deadlines are missed due to my dishonesty or non-cooperation.

5. Consumer Report Consent. I authorize AdventHealth, Physicians and Care Providers, or their assignees, to get consumer reports about me from one or more consumer reporting agencies to assist AdventHealth, Physicians and Care Providers, or their assignees, with their business activities related to billing, collecting, instituting payment arrangements, and/or determining eligibility for uncompensated care and/or government programs for past, current or upcoming Services at the hospital or outpatient center (whether or not such Service did, may, or will involve an extension of credit) or to resolve any outstanding Account balances. I understand AdventHealth, Physicians and Care Providers or their assignees may obtain consumer reports about me for Services at the hospital or outpatient center without my written permission under some circumstances as permitted by law. Consumer reports will not be pulled for Services provided at AdventHealth Medical Group or Centra Care locations.

6. Credit Balances. I give permission to apply any credit balances to pay for amounts due to AdventHealth, Physicians, and Care Providers for current Accounts or accounts I have not paid yet.

7. Hospital Laboratory Bills. Testing of fluids/specimens in AdventHealth's laboratory at the hospital is performed under the supervision of a Physician (i.e., pathologist) who may not perform the test or review results, but who does supervise and monitor reporting of the laboratory test results to ordering Physicians. As permitted by law, I AUTHORIZE PAYMENT BY MY BENEFITS FOR THE PHYSICIAN/PATHOLOGIST SUPERVISORY SERVICES. I understand I will not be billed for these supervisory services at the AdventHealth laboratory if my Benefits deny reimbursement.

CONSENT TO SHARING HEALTH INFORMATION:

I give consent to AdventHealth, Physicians and Care Providers to share the following health information as permitted by law and described below:

a. What Health Information: My name, address, contact information, financial information, diagnoses, treatment information which includes HIGHLY CONFIDENTIAL SUBSTANCE ABUSE, MENTAL HEALTH AND HIV/AIDS INFORMATION AS WELL AS INFORMATION IDENTIFIED IN THE ADVENTHEALTH JOINT NOTICE OF PRIVACY PRACTICES AS SUBJECT TO SPECIAL STATE LAWS, and any other information that is part of my health record with AdventHealth.

b. For What Purposes: Treatment, payment, and healthcare operations and as further described in the AdventHealth Joint Notice of Privacy Practices.

c. To Whom:

- Any person or entity responsible for (i) paying for or determining if I am eligible for payment for my treatment or for assigning my Benefits, and (ii) their healthcare operations.
- Physicians or Care Providers or my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, hospice, government or private agency which may provide medical, mental health, rehabilitation, social or related Services to me during a visit with, or during or upon my discharge or transfer from an AdventHealth facility.
- Physicians who have not treated me at AdventHealth, but who have my written permission to access my health information.
- Business partners (and their agents and vendors used to provide the services) of AdventHealth, Physicians or Care Providers who provide administrative, operational, financial, billing and collection, legal and technical support services.
- AdventHealth's affiliates, which are other entities owned or managed by AdventHealth or other physicians who are part of integrated physician or plan networks.
- AdventHealth's institutionally related foundation for fundraising purposes, but only when I have received treatment at the hospital and then only my name, address, contact information, age, gender, dates of services, health insurance status, department where services were provided in the hospital, treating physician(s), and outcome information.
- Recipients who are required or permitted by law to have access to my health information.

d. How Will It Be Shared: Hand delivery, mail, and electronically such as but not limited to electronic mail, facsimile, and through health information exchanges. Health information exchanges are entities that store and/or transfer health information electronically among providers to treat patients. This consent means that AdventHealth, Physicians and Care Providers may access my health information through health information exchanges and share my health information with other health care providers through health information exchanges. I understand my highly confidential information will be part of my health information shared or accessed.

e. Can I Stop Sharing My Health Information: Please review the AdventHealth Joint Notice of Privacy Practices and ask AdventHealth for the Request to Restrict Use and Disclosure of Protected Health Information form.

_____ (Initial Here) I give consent to AdventHealth, Physicians and Care Providers to use, share and access my health information as permitted by law and described above.

CONSENT TO CONTACT:

By signing this Agreement, I understand that I am giving permission to AdventHealth, Physicians, and Care Providers, and their independent contractors, agents, and assignees to call me and send messages (for example, text messages, emails, and chat messages etc.) to me at any time, at any telephone number including any current or subsequently obtained cellular or wireless number that I am a user or subscriber of that is provided by me or given to AdventHealth by a third party helping AdventHealth collect my debt, by using an automatic telephone dialing system or an artificial or prerecorded voice, for any purpose related to my healthcare and treatment, including prescription refill and appointment reminders, billing or collecting payment for my care (including financial assistance options), recommending possible treatment options or health-related benefits and services, and transportation arrangements. Consent to contact you for payment as described above continues

until you tell us to cancel your consent or you make payment in full or AdventHealth, Physicians or Care Providers waive or cancel your payment.

You may opt out of receiving text messages from AdventHealth at any time by texting STOP each time a message is sent to you from us. You may also select certain communication choices within the AdventHealth app. You may contact AdventHealth at any time to opt out of receiving auto-dialed or pre-recorded voice calls. AdventHealth reserves the right to have an AdventHealth staff member personally call you at any time about your treatment or payment for our Services.

ANY HANDWRITTEN CHANGES TO THIS FORM SHALL NOT BE LEGALLY BINDING OR ENFORCEABLE. I HAVE READ THIS AGREEMENT OR HAVE HAD IT READ TO ME. IT HAS BEEN EXPLAINED TO MY SATISFACTION.

DATE: _____ TIME: _____ Signature: _____

IF THE SIGNATURE ABOVE IS NOT THE PATIENT'S, WRITE THE NAME AND RELATIONSHIP OF THE PERSON SIGNING FOR THE PATIENT BELOW; AND IF THE PATIENT IS A MINOR, THE LEGAL REPRESENTATIVE REPRESENTS AND WARRANTS THE LEGAL REPRESENTATIVE IS A PARENT WITH LEGAL CUSTODY OR A LEGAL GUARDIAN OF THE MINOR.

DATE: _____ TIME: _____ Relationship: _____
(e.g., Parent, Guardian, Health Care Surrogate, Guarantor, Proxy, Power of Attorney)

Printed Name: _____

EMPLOYEE SIGNATURE IF PATIENT OR LEGAL REPRESENTATIVE IS NOT ABLE/UNWILLING TO SIGN.

Reason Patient Unable/Unwilling To Sign: _____

DATE: _____ TIME: _____ Signature: _____

IF INTERPRETER SERVICES ARE USED.

DATE: _____ TIME: _____ Signature: _____

Please write the interpreter name, badge ID number, language translated, method of translation (phone, video, or in-person), and interpreter signature if translation is in-person:

Joint Notice of Privacy Practices

Effective Date: April 1, 2024

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

If you have any questions about this notice, please contact our Privacy Officer at 800-906-1794/TTY: 407-200-1388.

Section A: Who Will Follow This Notice

This notice describes AdventHealth's practices and that of:

- Any health care professional authorized to enter information into your medical record maintained by an AdventHealth facility, such as doctors, nurses, physician assistants, technologists and others.
- All departments and units of AdventHealth facilities, including hospitals, outpatient facilities, physician practices, skilled nursing facilities, home health agencies, hospices, urgent care centers, and emergency departments.
- All employees, staff, students, volunteers and other personnel of AdventHealth facilities.
- All third-party business partners that assist AdventHealth with providing technology tools or other healthcare operations.

If you would like a list of AdventHealth affiliated entities, please send a written request to the Privacy Officer at the address below in Section G.

Section B: Our Pledge Regarding Your Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our facilities. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or maintained by AdventHealth facilities, whether made by our employees or your personal doctor. If your personal doctor is not employed by AdventHealth, your personal doctor may have different policies or notices regarding your doctor's use and disclosure

of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- ♦ Use our best efforts to keep medical information that identifies you private;
- ♦ Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- ♦ Follow the terms of the notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

We may share your medical information in any format we determine is appropriate to efficiently coordinate the treatment, payment, and health care operation aspects of your care. For example, we may share your information orally, via fax, on paper, or through electronic exchange.

We also ask you for consent to share your medical information in the admission documents you sign before receiving services from us. This consent is required by state law for some disclosures and allows us to be certain that we can share your medical information for the reasons described below. You may view a list of the main state laws that require consent (Attachment A) by clicking here <https://www.adventhealth.com/legal/patient-privacy-hipaa>, or you may ask the registration clerk for a paper copy. If you do not want to consent to these disclosures, please contact the Privacy Officer to determine if we can accept your request.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other AdventHealth personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of AdventHealth also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside AdventHealth who may be involved in your medical care for referrals, or your family members, friends, clergy or others we use to provide services that are part of your care.

- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at AdventHealth may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at AdventHealth, so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your health plan will cover the treatment.
- **Health Care Operations.** We may use and disclose medical information about you for AdventHealth's operations. These uses and disclosures are necessary to run AdventHealth and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may use and disclose your information as needed to conduct or arrange for legal services, auditing, or other functions. We may allow your medical information to be accessed, used or disclosed by our business associates that help us with our administrative and other functions. These business associates may include consultants, lawyers, accountants, software licensors and other third parties that provide services to us. For example, we license software with certain artificial intelligence enabled technology that processes data about you that is then reviewed by your physician or care provider to help treat you (e.g., the software within fetal heart monitors, and EKG and MRI machines) or to help your physician or care provider be more efficient (e.g., dictation software). The business associates may re-disclose your medical information only as necessary for our treatment, payment, health care operations and related functions, or for their own permitted administrative functions, such as carrying out their legal responsibilities. We may also combine medical information about many patients to decide what additional services AdventHealth should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other AdventHealth personnel for review and learning purposes. We may also combine the medical information we have with medical information from other entities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. Once we have removed information that identifies you, we may use the data for other purposes. We may also disclose your information for certain health care operation purposes to other entities that are required to comply with HIPAA if the entity has had a relationship with you. For example, another health care provider that treated you or a health plan that provided insurance coverage to you may want your medical information to review the quality of the services you received from them.
- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or

medical care at AdventHealth.

- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Fundraising Activities.** We may use information about you to contact you in an effort to raise money for AdventHealth and its operations. We may disclose information to a foundation related to AdventHealth so that the foundation may contact you to raise money for AdventHealth. We would release only contact information, such as your name, address, phone number, gender, age, health insurance status, the dates you received treatment or services at AdventHealth, the department you were treated in, the doctor you saw, and your outcome information. If you do not want AdventHealth to contact you for fundraising efforts, you must notify us in writing as set forth in Section G.
- **Patient Directory.** Unless you tell us otherwise, we may include certain limited information about you in AdventHealth's patient directory while you are a patient at AdventHealth. This information may include your name, location in AdventHealth, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Unless you tell us otherwise, your religious affiliation may be given to a member of the clergy, such as a minister, priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in AdventHealth and generally know how you are doing.
- **Individuals Involved in Your Care or Payment for Your Care.** Unless you tell us otherwise, we may release medical information about you to a friend or family member who is involved in your medical care; we may give information to someone who helps pay for your care; or we may tell your family or friends your condition and that you are in an AdventHealth facility. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes including to our research affiliates. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects involving people, however, are subject to a special approval process by an Institutional Review Board. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, unless most or all of the patient identifiers

are removed, the project will have been approved through this research approval process. We may, however, provide limited read-only access to medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review remains protected. If required by law, we will ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at AdventHealth.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal, state or local law. For example, when our patients have certain transmissible diseases, suffer from abuse, neglect or assault, or for state registries such as the Office of Vital Statistics or tumor registries. Another example would be for work related injuries or illnesses, or workplace related medical surveillance.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Section D: Special Situations

- **Organ and Tissue Donation.** We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may also disclose information to entities that determine eligibility for certain veterans' benefits.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
 - To prevent or control disease, injury or disability;
 - To report births and deaths;
 - To report child abuse or neglect;
 - To report reactions to medications or problems with products;
 - To notify people of recalls of products they may be using;
 - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** We may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
 - In response to a court order, subpoena, warrant, summons or similar process;
 - To identify or locate a suspect, fugitive, material witness, or missing person;
 - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
 - About a death we believe may be the result of criminal conduct;
 - About criminal conduct at AdventHealth; and
 - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of AdventHealth to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your

health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy some of the medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. When your medical information is contained in an electronic health record, as that term is defined in federal laws and rules, you have the right to obtain a copy of such information in an electronic format and you may request that we transmit such copy directly to an entity or person designated by you, provided that any such request is in writing and clearly identifies the person we are to send your PHI to. If you request a copy of the information, we may charge a fee for the costs of labor, copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy medical information in certain circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting

the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the healthcare entity. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- ♦ Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- ♦ Is not part of the medical information kept by or for the healthcare entity;
- ♦ Is not part of the information which you would be permitted to inspect and copy; or
- ♦ Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. The accounting will exclude certain disclosures as provided in applicable laws and rules such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members

involved in your care, disclosures for notification purposes and certain other types of disclosures made to correctional institutions or law enforcement agencies. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

We are not required to agree to your request, except in limited circumstances where you have paid for medical services out-of-pocket in full at the time of the service and have requested that we not disclose your medical information to a health plan. To the extent we are able, we will restrict disclosures to your health plan. We will not be able to restrict disclosures of your medical information to a health plan if the information does not relate solely to the health care item or service for which you have paid in full. For example, if you are having a hysterectomy that will be paid for by your health plan, and you request to pay cash for a tummy tuck that you want performed during the same surgery, to avoid disclosure to your health plan, you would either have to pay cash for the entire procedure or schedule the procedures on separate days. Please also know that you have to request and pay for a restriction for all follow-up care and referrals related to that initial health care service that was restricted in order to ensure that none of your medical information is disclosed to your health plan. You, your family member, or other person may pay by cash or credit, or you may use money in your flexible spending account or health savings account. Please understand that your medical information will have to be disclosed to your flexible spending account or health savings account to obtain such payment.

If we do agree, we will comply with your request unless the disclosure is otherwise required or permitted by law. For example, we may disclose your restricted information if needed to provide you with emergency treatment.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to

be contacted.

- **Right to a Notice of Breach.** You have the right to receive written notification of a breach if your unsecured medical information has been accessed, used, acquired or disclosed to an unauthorized person as a result of such breach, and if the breach compromises the security or privacy of your medical information. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first-class mail or, if necessary, by such other substituted forms of communication allowable under the law.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, <https://www.adventhealth.com/legal/patient-privacy-hipaa>.
- **Right to Decline Participation in Health Information Exchange.**

AdventHealth has electronically connected patient medical information to the AdventHealth health information exchange application known as Epic's Care Everywhere and other related applications and services ("HIE applications"). HIE applications provide interoperability functions that connect us with other health information exchange organizations to share patient medical information to and from other health care providers, Health Information Service Providers (HISP), health plans, and government agencies. Making patient medical information available through the AdventHealth HIE applications promotes efficiency and quality of care.

You may choose not to allow your medical information to be shared through the AdventHealth HIE applications. Sharing medical information through the AdventHealth HIE applications is not a condition of receiving care. To opt-out of the AdventHealth HIE applications, send a written request to the Privacy Officer at the address or email address provided in section G below or request to sign an HIE application cancellation form when you visit an AdventHealth facility. Please note that any medical information about you previously made available through HIE applications to other recipients is not controlled by AdventHealth. To opt-out of certain other national, regional or state health information exchanges, you must contact the specific HIE applications or your other providers or insurance companies and follow their opt-out process.

Once AdventHealth processes your HIE application opt-out request, healthcare providers outside of AdventHealth can no longer view your medical information originating from AdventHealth. This means it may take longer for healthcare providers external to AdventHealth to get medical information they may need to treat you. Your opt-out request will remain in effect until you provide a written request to AdventHealth to start sharing your medical information through the AdventHealth HIE again. Even if you do not participate in a health information exchange, certain state law reporting requirements, such as the immunization

registry, will still be fulfilled through health information exchange. Some states also allow healthcare providers to access your medical information through a national, regional, or state health information exchange if needed to treat you in an emergency.

To exercise the above rights, please contact the following individual to obtain a copy of the relevant form you will need to complete to make your request:
The Privacy Officer at 800-906-1794/TTY: 407-200-1388.

Section F: Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in AdventHealth, as well as on our website. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to an AdventHealth facility for treatment or health care services, we will make available a copy of the current notice in effect.

Section G: Do You Have Complaints or Concerns?

If you believe your privacy rights have been violated, you may file a complaint with AdventHealth or with the Secretary of the Department of Health and Human Services. To file a complaint with AdventHealth, please contact: The Privacy Officer at 800-906-1794/ TTY: 407-200-1388, or email at patientrequest@adventhealth.com, or send mail to AdventHealth, 900 Hope Way, Altamonte Springs, FL 32714, Attn: Privacy Officer. All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

Section H: Other Uses of Medical Information That Require Your Authorization

The following types of uses and disclosures of medical information will be made only with your written permission.

- **Psychotherapy Notes.** Psychotherapy notes are notes that your psychiatrist or psychologist maintains separate and apart from your medical record. These notes require your written authorization for disclosure unless the disclosure is required or permitted by law, the disclosure is to defend the psychiatrist or psychologist in a lawsuit brought by you, or the disclosure is used to treat you or to train students.
- **Marketing.** We must get your permission to use your medical information for marketing unless we are having a face-to-face talk about the new health care product or service, or unless we are giving you a gift that does not cost much to tell you about the new health care product or service. We must also tell you

if we are getting paid by someone else to tell you about a new health care item or service.

- **Selling Medical Information.** We are not allowed to sell your medical information without your permission and we must tell you if we are getting paid. However, certain activities are not viewed as selling your medical information and do not require your consent. For example, we can sell our business, we can pay our contractors and subcontractors who work for us, we can participate in research studies, we can get paid for treating you, we can provide you with copies or an accounting of disclosures of your medical information, or we can use or disclose your medical information without your permission if we are required or permitted by law, such as for public health purposes.

If you provide us with authorization to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Section I: Organized Health Care Arrangement

AdventHealth, its Medical Staff, and other health care providers affiliated with AdventHealth have agreed, as permitted by law, to share your medical information among themselves for purposes of your treatment, payment or health care operations at AdventHealth. We may participate in organized health care arrangements with other covered entities, like other health care providers, that are not our agents for purposes of joint utilization review, quality assessment and improvement activities, or payment activities. Each are independent entities responsible for their own activities. This enables us to better address your health care needs.

In an effort to control health care costs, while still providing quality care, AdventHealth, independent contractor members of its Medical Staff and other health care providers in the communities where AdventHealth provides services have also joined together or may be in the process of joining together to create networks of providers or accountable care organizations to provide and manage your treatment, as well as to conduct population health research to improve the quality of care in our communities. We ask you to consent to the release of your medical information and super sensitive data in our admission documents when you come to our facility. If you would like to restrict these disclosures, please contact the Privacy Officer as set forth in Section G to determine if we can accept your request. Please also contact our Privacy Officer if you would like to see a list of the networks, organized health care arrangements, affiliated covered entities, or accountable care organizations AdventHealth participates in.

SUMMARY OF THE PATIENT'S

Rights and Responsibilities

Federal and state law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the Florida Patient Rights law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

Patient Rights:

General Rights

- A patient has the right to impartial access to medical treatment or accommodations, regardless of age, sex, race, color, national origin, ethnicity, religion, handicap, culture, language, physical or mental disability, socioeconomic status, sexual orientation, gender identity or expression, or source of payment.
- A patient has the right to be treated with courtesy and respect, with appreciation of his or her cultural and personal values, beliefs, preferences, individual dignity, and with protection of his or her right to and need for privacy.
- A patient has a right to religious and spiritual accommodation.
- A patient has the right to be free from neglect, harassment, exploitation, verbal, physical, mental, and sexual abuse to receive care in a safe setting.
- A patient has a right to have his or her allegations, observations and suspected cases of neglect, exploitation, and abuse reported to appropriate authorities based on the hospital's evaluation of the suspected events as required by law.
- A patient has the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff and to be subjected to restraint or seclusion only by trained staff to ensure the immediate physical safety of the patient, a staff member, or others and to have it discontinued at the earliest possible time.
- A patient has the right to bring any person or receive or deny visitors of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety, rights, or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.
- A patient has the right to know what rules and regulations apply to his or her conduct.

Quality of Care and Decision Making

- A patient has the right to have a family member or representative of his or her choice and his or her physician notified promptly of his or her admission to the hospital.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to receive information in a manner the patient understands.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to the means to make informed decisions.

- A patient has the right to participate in the development and implementation of their plan of care.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to pain management.
- A patient has the right to request or refuse any treatment, including life-prolonging procedures, except as otherwise provided by law.
- A patient has the right to participate in the consideration of ethical issues that arise in his or her care.

Advance Directives (Designation of Health Care Surrogate and Living Will)

- A patient has the right to written information concerning the health care facility's policies respecting Advance Directives.
- A patient has the right to formulate, review, or revise Advance Directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives.
- A patient has the right, upon request, to be referred to resources for assistance in formulating Advance Directives.
- A patient has the right to not have treatment or admission conditions upon whether or not the individual has executed or waived an individual directive.

Privacy and Confidentiality

- A patient has the right to confidentiality of his or her clinical records and to access current medical records in such form and format as agreeable to by the facility and individual, and within a reasonable time frame.

Finances

- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request and prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to receive notice of non-coverage and a right to appeal premature discharge.

Research and Clinical Trials

- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research without any impact on his or her access to care, treatment, and services unrelated to the research.
- A patient has the right to a prompt and reasonable response to questions and requests.

- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient has the right to information regarding the process of submitting a written or verbal grievance.

Patient Responsibilities:

- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for asking questions or acknowledging to the health care provider when he or she does not comprehend a treatment course or care decision and what is expected of him or her.
- A patient is responsible for supporting mutual consideration and respect by maintaining civil language and conduct in interactions with staff and licensed independent practitioners.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Concerns or Complaints

Your satisfaction is important to us. If you have a concern or a complaint, please allow the person responsible for your care or their supervisor the opportunity to listen, review, and to assist you with an appropriate resolution. If your complaint is unresolved, please ask to speak to the department's manager, director or the house supervisor. If your concern cannot be resolved by the AdventHealth process indicated, please allow the facility the opportunity to address your grievance.

Facility	Contact	
Altamonte	Risk Management	407-200-1330
Apopka	Risk Management	407-200-1330
Carrollwood	Administration	813-558-8001
Celebration	Risk Management	407-200-1330
Dade City	Risk Management	813-783-6119 ext. 1614
Daytona Beach	Risk Management	386-231-3185
Deland	Risk Management	386-943-4840
East Orlando	Risk Management	407-200-1330
Fish Memorial	Risk Management	386-917-5254
Heart of Florida	Risk Management	863-419-2506
Kissimmee	Risk Management	407-200-1330
Lake Placid	Patient Advocate	863-402-3421 or 863-402-5333
Lake Wales	Risk Management	863-679-6825
New Smyrna	Risk Management	386-424-5052
North Pinellas	Risk Management	727-942-5069
Ocala	Risk Management	352-402-5032
Orlando	Risk Management	407-200-1330
Palm Coast	Risk Management	386-586-4229
Palm Coast Parkway	Risk Management	
Riverview	Risk Management	656-233-5822
Port Charlotte	Risk Management	941-766-4815
Sebring	Patient Advocate	863-402-3421 or 863-402-5333
Tampa	Risk Management	813-615-7204
Waterman	Risk Management	352-253-3195
Wauchula	Patient Advocate	863-402-3421 or 863-402-5333
Wesley Chapel	Risk Management	813-929-5000
Winter Garden	Risk Management	407-200-1330
Winter Park	Risk Management	407-200-1330
Zephyrhills	Risk Management	813-783-6119 ext. 1614

The following agencies may be contacted:

Facility	Accreditation Agency	Licensing Agency
Altamonte	Hospital Complaint DNV Healthcare Inc.: https://www.dnvhealthcareportal.com/patient-complaint-report . Mail: Attn: Healthcare Complaints DNV Healthcare USA Inc. 4435 Aicholtz Road Suite 900 Cincinnati, OH 45245 Fax: 281-870-4818 Phone: 866-496-9647 E-mail: hospitalcomplaint@dnv.com	Agency for HealthCare Administration Complaint Administration Unit 2727 Mahan Drive Tallahassee, FL 32308 Phone: 888-419-3456
Apopka		
Celebration		
East Orlando		
Heart of Florida		
Kissimmee		
Lake Wales		
Riverview		
Orlando		
Tampa		
Wesley Chapel		
Winter Garden		
Winter Park		
Carrollwood	Joint Commission: https://www.jointcommission.org/resources/patient-safety-topics/report-a-patient-safety-concern-or-complaint/ Mail: Print form from website and mail to: Office of Quality Monitoring The Joint Commission One Renaissance Boulevard Oakbrook Terrace, IL 60181	Agency for HealthCare Administration Complaint Administration Unit 2727 Mahan Drive Tallahassee, FL 32308 Phone: 888-419-3456
Dade City		
Daytona Beach		
Fish Memorial		
Deland		
Lake Placid		
New Smyrna		
North Pinellas		
Ocala		
Palm Coast		
Palm Coast Parkway		
Port Charlotte		
Sebring		
Waterman		
Wauchula		
Zephyrhills		



Hospital Quality Measures/Patient Safety Information

Hospital name: ADVENTHEALTH KISSIMMEE

Date: 10/2/2024

Patients admitted to the hospital for treatment of medical problems sometimes experience other serious injuries, complications, or conditions. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

Health Care Associated Infections (HAI)

April 2022 through March 2023

HAIs are infections that occur while a patient is being treated in a hospital. Many of these infections can be prevented through the use of proper procedures and precautions. Infection reports compare the infections at a hospital to a national benchmark.

	Catheter Associated Urinary Tract Infection	Central-line Associated Bloodstream Infection	Clostridium Difficile Infections	Methicillin-resistant Staphylococcus aureus	Surgical Site Infection from Colon Surgery	Surgical Site Infection from Abdominal Hysterectomy
State Benchmark	0.658	0.652	0.481	1.063	0.937	0.726
Facility Rating	N/A	N/A	N/A	N/A	N/A	N/A

★★★ Better than the U.S. National Benchmark
★★ No different than the U.S. National Benchmark
★ Worse than the U.S. National Benchmark
N/A No results available

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

April 2022 through March 2023

Patient surveys measure satisfaction with hospital care, nurse and doctor communication, staff response to needs, and the cleanliness and quietness of the hospital.

	Overall Hospital Rating
National Average	72%
State Average	66%
Facility Overall Rating	N/A

★ The star ratings range from ★ - ★★★★★ stars
(%) The percent of patients surveyed who gave the hospital the highest possible score
N/A No results available

15-Day Readmission Rate

January 2022 through December 2022

Patients should not normally be readmitted to a hospital within 15 days of a hospital stay for the same or a related condition. A low 15-Day readmission rate generally means the hospital is doing a better job of managing a patient's condition and helping arrange proper post-hospital care coordination.

	15-day Readmission Rate
Statewide Rate	6.39%
Facility Rate	7.67% (As Expected)

(%) The percentage of patients readmitted within 15 days of initial discharge
(As Expected, Lower than Expected, or Higher than Expected) is based on the severity of patients seen.
N/A No results available

For more information: FloridaHealthFinder.gov: <https://www.floridahealthfinder.gov/Compare-Care/Glossary>
HCAHPS: Patients' Perspectives of Care Survey Webpage: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS>

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, including a hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” means providers and facilities that haven't signed a contract with your healthplan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, including a hospital or ambulatory surgery center, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Please see below for information regarding Florida law.

Certain services at an in-network facility

When you get services from an in-network facility, including a hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

Please see below for information regarding Florida law.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

Florida Law

Florida law generally contains balance billing protections similar to those under the No Surprises Act (as described in this Notice), *except that* if you have a certain type of health plan (i.e., fully funded commercial plans, such as preferred provider ("PPO") or exclusive provider plans ("EPO")), your provider cannot bill you more than your in-network, cost-sharing amount even if you provide consent. If you have one of these plans, Florida also extends balance billing protections to covered emergency and non-emergency services provided at an urgent care center. If you are unsure whether you have one of these plans, please review your insurance card, call your insurance carrier or contact [AdventHealth patient financial services at 407-303-0500].

If you think you've been wrongly billed, contact the HHS No Surprises Helpdesk at 1-800-985-3059, which is the entity responsible for enforcing the federal balance or surprise billing protection laws. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Florida also has an independent dispute resolution process to resolve claims-related issues, including disputes with your provider or insurance plan pertaining to receipt of improper balance bills. If you have received an improper balance bill from your provider, you may file a complaint with the Florida Department of Agriculture and Consumer Services by visiting <https://www.fdacs.gov/#>. If you have received an improper balance bill from your insurer, you may file a complaint with the Florida Office of Insurance Regulation, Department of Financial Services, at <https://myfloridacfo.com/division/consumers/>.

minimal risk of side-effects due to low absorption of the medication into the blood stream. Compounded topicals prepared by a pharmacist can be customized to the patient's specific needs.

Interventional pain management. "Interventional" procedures might include an injection of an anesthetic medicine or steroid around nerves, tendons, joints or muscles; spinal cord stimulation; insertion of a drug delivery system; or a procedure to stop a nerve from working for a long period of time.

Non-opioid anesthesia. Non-opioid anesthesia refers to the anesthetic technique of using medications to provide anesthesia and post-operative pain relief in a way that does not require opioids. Anesthetists can replace opioids with other medications selected for their ability to block surgical and post-surgical pain. By replacing opioids and incorporating the variety of anesthetic and analgesic medications that block the process of pain, anesthesia providers can provide a safer anesthetic that avoids the adverse effects of opioids.

Discuss these alternatives with your healthcare practitioner and talk about the advantages and disadvantages of the specific options being considered. Different approaches work better on different types of pain. Some treatments for pain can have undesirable side effects while others may provide benefits beyond pain relief. Depending on your insurance coverage, some options may not be covered, resulting in substantial out-of-pocket costs. Other options may require a significant time commitment due to the number of treatments or the time required for the treatment. Good communication between you and your healthcare practitioner is essential in building the best pain management plan for you.

Helpful Hints and Links

When you are selecting a healthcare practitioner, you can verify their license and find more information at: <https://apps.mqa.doh.state.fl.us/MQASearchServices/Home>

You can find more information at these links.

National Institutes of Health: <https://nccih.nih.gov/health/pain/chronic.htm>
Centers for Disease Control and Prevention: https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf



Information on Nonopioid Alternatives for the Treatment of Pain

A guide to working with your healthcare practitioner to manage pain

Prescription opioids are sometimes used to treat moderate-to-severe pain. Because prescription opioids have a number of serious side effects, it is important for you to ask questions and learn more about the benefits and risks of opioids. Make sure you're getting care that is safe, effective, and right for you.



This pamphlet provides information about nonopioid alternative treatments to manage pain. You and your healthcare practitioner can develop a course of treatment that uses multiple methods and modalities, including prescription medications such as opioids, and discuss the advantages and disadvantages of each approach.

Pain management requires attention to biological, psychological, and environmental factors. Before deciding with your healthcare practitioner about how to treat your pain, you should consider options so that your treatment provides the greatest benefit with the lowest risk.

Cold and heat. Cold can be useful soon after an injury to relieve pain, decrease inflammation and muscle spasms, and help speed recovery. Heat raises your pain threshold and relaxes muscles.

Exercise. Staying physically active, despite some pain, can play a helpful role for people with some of the more common pain conditions, including low back pain, arthritis, and fibromyalgia.

Weight loss. Many painful health conditions are worsened by excess weight. It makes sense, then, that losing weight can help to relieve some kinds of pain.

Diet and nutrition. Chronic pain may be the result of chronic inflammation. Some foods can increase inflammation and contribute to pain levels. Reducing or eliminating foods that increase inflammation may provide pain relief.

Yoga and tai chi. These mind-body and exercise practices incorporate breath control, meditation, and movements to stretch and strengthen muscles. They may help with chronic pain conditions such as fibromyalgia, low back pain, arthritis, or headaches.

Transcutaneous electrical nerve stimulation (TENS). This technique employs a very mild electrical current to block pain signals going from the body to the brain.

Over-the-counter medications. Pain relievers that you can buy without a prescription, such as acetaminophen (Tylenol) or nonsteroidal anti-inflammatory drugs (NSAIDs) like aspirin, ibuprofen (Advil, Motrin), and naproxen (Aleve, Naprosyn) can help to relieve mild to moderate pain.



Treatments provided by Licensed Healthcare Providers

Physical therapy (PT) and occupational therapy (OT). PT helps to increase flexibility and range of motion which can provide pain relief. PT can also restore or maintain your ability to move and walk. OT helps improve your ability to perform activities of daily living, such as dressing, bathing, and eating.

Massage therapy. Therapeutic massage may relieve pain by relaxing painful muscles, tendons, and joints; relieving stress and anxiety; and possibly impeding pain messages to and from the brain.

Acupuncture. Acupuncture is based on traditional Chinese medical concepts and modern medical techniques and provides pain relief with no side-effects by stimulating the body's pain-relieving endorphins. Techniques may include inserting extremely fine needles into the skin at specific points on the body.

Chiropractic care. Chiropractic physicians treat and rehabilitate pain, diseases and conditions using manual, mechanical, electrical, natural methods, physical therapy, nutrition and acupuncture. Chiropractors practice a hands-on, prescription drug-free approach to health care that includes patient examination, diagnosis and treatment.

Osteopathic Manipulative Treatment (OMT). Osteopathic physicians (DO) are educated, trained, and licensed physicians, but also receive additional training in OMT. OMT is a set of hands-on techniques used by osteopathic physicians to diagnose, treat, and prevent illness or injury. OMT is often used to treat pain but can also be used to promote healing, increase overall mobility, and treat other health problems.

Behavioral interventions. Mental health professionals can offer many avenues for pain relief and management. For example, they can help you reframe negative thinking patterns about your pain that may be interfering with your ability to function well in life, work, and relationships. Behavioral interventions can allow you to better manage your pain by changing behavior patterns.

Topical treatments and medications. Topical Agents, including Anesthetics, NSAIDs, Muscle Relaxers, and Neuropathic Agents, can be applied directly to the affected areas to provide needed pain relief and typically have a

Opioid Dependence Clinical Documentation Integrity Best Practices

General Information

Terms such as “Drug use” and “drug abuse” do not capture the patient’s acuity and complexity. Documentation of Opioid Dependence should include the specific drug or classification of drug, the level of usage such as use, abuse, or dependence, and any associated complications or disorders if known. (E.g., Opioid dependence with withdrawal, Constipation secondary to Opioid use)

Criteria

Opioid Dependence

- **Use:** Consumes opioids on a regular basis by their own initiative with no obvious clinical manifestations.
- **Abuse:** Exhibits a maladaptive pattern of opioid use leading to clinically significant impairment or distress of substances not taken for therapeutic purposes.
- **Dependence:** Indicates compulsive and continuous consumption of opioids, leading to significant clinical manifestations and a physiological need for the substance to function normally. The patient develops a tolerance or the need for larger doses of opioids to achieve the same results. Any discontinuation of opioids results in signs and symptoms of withdrawal.

Documentation Tips

Avoid	Document
• Drug use w/ W/D • Patient abruptly stopped taking chronic pain meds, nausea, vomiting, sweating	• Specified type of drug with withdrawal • Opioid dependence with withdrawal

Pro Tips

Consider linking opioid use, abuse, or dependence with a substance-induced complication to assist with risk adjustment:

- Intoxication or Intoxication delirium
- Psychotic or Mood disorder
- Withdrawal
- Hallucinations or Delusions
- Sexual dysfunction



Scan QR code to verify participation.

Reference: [ACDISPro](#)

The Lincoln Memorial University-DeBusk College of Osteopathic Medicine (LMU-DCOM) is accredited by the American Osteopathic Association to provide osteopathic continuing medical education for physicians. LMU-DCOM designates this program for a maximum of 0.5 AOA Category 2-B credits per three flyers completed and will report CME and specialty credits commensurate with the extent of the physician's participation in this activity. The University of New England College of Osteopathic Medicine (UNE COM) is accredited by the Maine Medical Association's Council on Continuing Medical Education and Accreditation (MMA CCMEA) to provide continuing medical education for physicians. UNE COM designates this educational activity for a maximum of 0.5 AMA PRA Category 1 Credit(s)™ per three flyers completed and 0.5 University of New England contact hours per three flyers completed for non-physicians. Contact hours may be submitted by non-physician, non-PA health professionals for continuing education credits. This activity has been planned and implemented in accordance with the accreditation requirements and policies of the ACCME through the joint providership of University of New England and LMU-DCOM. University of New England is accredited by the Maine Medical Association to provide continuing medical education for physicians.



CITIZENSHIP STATUS ACKNOWLEDGEMENT

AdventHealth is required by Florida law to ask you for your citizenship status.

You are not required to produce any documents or papers to verify your answers to these questions.

Emergency care will not be withheld to ask or get an answer to these questions.

You are not required to answer these questions to get treated.

Your answers to these questions will not be reported to law enforcement.

Based on the answers to these questions, AdventHealth is required to report back to the State of Florida four times per year with the number of US citizens or persons legally present in the US, the number of persons unlawfully present in the US, and the number of patients that declined to answer these questions during the prior 3-month period. **No specific information that will identify you will be included in this report. The information is de-identified.** This report will help the State of Florida know how much money is paid each year for uncompensated care related to individuals unlawfully present in the US.

Once you have read and understand this notice, please let us know so we can ask you questions about your citizenship status.

I have read and understand this form.

Advance Directives

Making your Wishes Known

It is vital for your health care providers and family to know what is most important to you so we can honor your wishes. **Advance Directives** guide others to make medical care decisions you would make for yourself if you are unable to speak for yourself. This packet provides general information and Advance Directive forms to complete, which includes a Health Care Surrogate Designation form and a Living Will.

What do I do after completing my Advance Directive form?

- It is very important that you discuss your wishes and medical care with your Health Care Surrogate, family, and health care providers so they can honor your wishes.
- Share copies of this form with your Health Care Surrogate, doctors, nurses, caregivers, family, and friends as appropriate.
- Keep a copy for yourself that someone can easily find.
- Consider reviewing your forms every few years and during any major health event because your wishes may change.

What if I change my mind?

- You can change your mind at any time.
- Your spoken wishes about medical treatment must be honored even if different from your forms.
- If your wishes change it is best to fill out a new form and update your Health Care Surrogate and medical team.

Please talk to your physician, clergy, or attorney if you have further questions.

The **Health Care Surrogate** is a person you trust and name to make medical decisions when you are too sick to make your own decisions or are able to make decision but would like your surrogate to make medical decisions on your behalf. Your Health Care Surrogate should make decisions guided by your Living Will. In some situations, your Health Care Surrogate will be asked to make decisions based on your best interest. Often family members are good choices, but not always.

When you choose a Health Care Surrogate consider:

- Someone who is 18 years of age or over and is mentally competent to make decisions.
- Someone who understands your personal, social, and spiritual values and will advocate for you.
- Someone who will honor and advocate for your wishes even if they are different from their own.
- Someone who will be available and can work well with the medical team.
- Someone who can handle stressful family situations.

What if I do not choose a Health Care Surrogate?

If you are too sick to make your own decisions and you do not name a Health Care Surrogate, your Next of Kin will be your decision maker which would include the following, in the highest order of priority:

1. Spouse
2. Adult children
3. Parent(s)
4. Adult sibling(s)
5. Adult relative(s)
6. Close personal friend (by notarized affidavit)

Patient Label

Designation of Health Care Surrogate Form

In the event that I, (full name) _____, am no longer able to make my own health care decisions, I choose as **my Health Care Surrogate**:

Name: _____ / _____
First Name Last Name Phone #

Address: _____

If my Health Care Surrogate is unwilling or unable to perform these duties, I choose as **my alternative Health Care Surrogate**:

Name: _____ / _____
First Name Last Name Phone #

Address: _____

My Health Care Surrogate's authority becomes effective when my physician(s) determine that I am unable to make my own health care decisions.

Optional: I also have the option to choose that my Health Care Surrogate's authority become **effective immediately** even while I am competent by initialing either or both of the following boxes:

I MUST initial:

_____ My Health Care Surrogate has authority to receive my health information while I'm competent.
Initial

_____ My Health Care Surrogate has authority to make health decisions for me even while I am
Initial competent. However, any instructions or health care decisions I make, either verbally or in writing, will supersede any instructions or health care decisions made by my Health Care Surrogate while I have the capacity to do so.

Specific instructions or restrictions: _____

I authorize my health care surrogate to make all health care decisions for me, which means he or she has the authority to:

- Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
- Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
- Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
- Decide to make an anatomical gift.

My Signature: _____ **Date:** ____/____/____ **Time:** _____

1st Witness (required): _____

2nd Witness (required): _____

Witness Signatures: Two required. Your Health Care Surrogate **cannot** be a witness. Only one witness can be your family or spouse. You do not need a notary.

☐ Phone

OR ☐ Video

Qualified Staff / Interpreter Signature (Check) Print Qualified Staff / Interpreter Name ID Number Language Interpreted



LIVING WILL INFORMATION

The **Living Will** lets your health care team, family and others know your wishes regarding life support treatment and how to apply them to your medical care. **Life support treatments** are used when you are very sick. These treatments are often helpful, but in certain situations can only add to suffering and prolong the dying process. The difference between prolonging life and prolonging suffering depends on your values about what makes life worth living. Often when you are so sick that you may die soon you are unable to speak for yourself. This part helps you keep a 'voice' in your care when you are not able to speak.

Life support treatments may include, but are not limited to, **medicines, surgeries, invasive procedures**, such as:

- **Intubation with a breathing machine or ventilation:** when a tube is placed through your mouth to your lungs, or a tracheostomy tube in your neck, so that a machine can pump air into your lungs and breathe for you.
- **Artificial feeding:** this would include a feeding tube or TPN (IV nutritional support) if you cannot swallow.
- **IV Fluids:** for hydration and administration of medications
- **Blood transfusions:** to put other blood or blood products into your veins
- **Dialysis:** a machine that cleans your blood if your kidneys stop working

LIVING WILL FORM

My wish is if I am very sick: (Initial **EITHER** Section I or II below)

Section I. I do not want any life support treatment if I am in a: (initial all that apply)

_____ **Persistent Vegetative State:** a permanent condition of unconsciousness, meaning you cannot interact
Initial with the world and have no voluntary actions or thinking behavior.

_____ **End Stage Condition:** an irreversible condition that causes severe worsening and permanent decrease in
Initial health where treatment would not likely work.

_____ **Terminal Condition:** a condition where there is likely no probability of recovery and it is expected to cause
Initial death without treatment.

I do _____ (*initial*) or I do **not** _____ (*initial*) want to be given nutrition and / or hydration artificially by a feeding tube or by intravenous feedings when it would serve only to prolong artificially the process of dying.

I willfully and voluntarily make known my desire that my dying not be artificially prolonged under the above initialed circumstances. I request to be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain

OR

Section II.

_____ **I do want to try** the life support treatments my physician thinks might help. If the treatments **do not**
Initial **work** and there is little hope of getting better, **I do not want** to stay on life support machines.

Additional Instructions (Optional): _____

I request that my Living Will be honored by my family and medical team and I accept the consequences of my choices. I am thinking clearly.

My Signature: _____ **Date:** ____/____/____ **Time:** _____

1st Witness (required): _____

2nd Witness (required): _____

Witness Signatures: Two required. Only one witness can be your family or spouse. You do not need a notary.

☐ Phone

OR ☐ Video

Qualified Staff / Interpreter Signature

(Check) _____
Print Qualified Staff / Interpreter Name

ID Number

Language Interpreted



ADDITIONAL IMPORTANT INFORMATION REGARDING YOUR WISHES TO SHARE WITH YOUR HEALTH CARE TEAM AND HEALTH CARE SURROGATE / FAMILY

A Living Will is NOT a “Do Not Resuscitate” (DNR) order.

If you do not want Cardiopulmonary Resuscitation (CPR) in the event you have a cardiac or respiratory arrest, you will need to speak to your physician to order a “Do Not Resuscitate” (DNR) (Allow Natural Death) order. A specific “DNR order” is required which tells the medical team how to treat you in the event your heart and / or lungs stop working. It does **not** mean “Do Not Treat” before your heart/lungs stopped. If you are a patient, you will receive care and treatment recommended by your physician and agreed upon by you. Please talk with your health care provider about your current medical condition as well as the benefit and harm of each treatment option.

Cardiopulmonary Resuscitation (CPR) is an attempt to resume your heart and lung function if your heart or lungs stop working. CPR may include:

- Chest compressions – pressing in a hard-repetitive motion on your chest to attempt to keep your blood flowing
- Defibrillation - Electric shocks to attempt to restart your heart
- Medicines in your veins
- Intubation with a breathing machine or ventilation

If CPR is successful, you usually would be in the Intensive Care Unit on a breathing machine and other treatment therapies, if needed.

If you decide you do not want CPR measures taken in the event of a cardiac and/or respiratory arrest, you (or your health care surrogate or next of kin on your behalf if you are unable to make medical decisions) will need to sign a separate “Do Not Resuscitate” (DNR) Order form. There are two types of DNR forms, hospital specific and community. Your health care provider can provide you more information regarding the most appropriate DNR order form for use based on your wishes.

If you are a patient in the hospital, speak with your physician regarding having a Do Not Resuscitate Order form completed.

If you are in the community, you may download and print the State of Florida Do Not Resuscitate Order form. You may access the form at <http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/do-not-resuscitate/index.html>. This form must be printed on yellow paper and signed by yourself and your physician to be honored by the community Emergency Medical Services.

Understanding Your Emergency Room Cost

When you visit the emergency room, your health and safety are our top priorities. We also understand that concerns about unexpected medical bills can add stress during an already difficult time. That's why we're committed to being clear and supportive when it comes to your billing and insurance information. Every situation is unique, and our team is here to help you understand your coverage and explore your options.

Why Are We Asking for Payment?

At the time of your ER visit, we may ask for payment or provide you with an estimate based on your insurance coverage. This is a standard part of the registration process and helps:



Meet Insurance Requirements:

Many insurance plans require a copay or deductible to be collected at the time of service.



Avoid Surprise Bills with Estimate Transparency:

By getting payment information in advance, we can provide transparency throughout the billing cycle and more accurately bill your insurance, preventing delays.



Cost Transparency:

We'll help you understand your estimated out-of-pocket costs upfront.

What You Might Be Asked to Pay:

Depending on your situation, we may request:

- **Insurance co-payments**
- **Deductible or coinsurance estimates**
- **A deposit** if you do not have insurance

What if you can't make a payment? We have options for you:

We never delay emergency care due to an inability to pay. If you're unable to make a payment:

- You will **still receive medical treatment**
- We can **discuss flexible payment options**
- **Financial assistance** may be available for those who qualify

Please let our staff know if you have questions or need help navigating your options.

Questions About Billing or Insurance?

Our Consumer Access and Patient Financial Services teams are here to help.

- 📞 Call: 855-AH1-BILL (855-241-2455).
- 🌐 Visit: <https://www.adventhealth.com/pay-my-bill>
- 👤 Ask for a Financial Counselor on site

Thank you for choosing AdventHealth to care for you. We're dedicated to helping you feel whole, in body, mind and spirit.