This CONDITIONS OF ADMISSION and/or TREATMENT AGREEMENT (the "AGREEMENT") applies to all services provided or visits started during this period: ___/___/___ to ___/___/___. This Agreement expires no earlier than ___/___/___, and only when all treatment/hospital charges have been paid in full and there is a zero balance on the resulting account.

(FROM DATE) (TO DATE) (TO DATE)

This agreement applies to The Medical College of Wisconsin, Inc. ("MCW") and Froedtert Health affiliates: Froedtert Memorial Lutheran Hospital, Inc.; Community Memorial Hospital of Menomonee Falls, Inc.; St. Joseph's Community Hospital of West Bend, Inc.; Froedtert & the Medical College of Wisconsin Community Physicians, Inc.; West Bend Surgery Center, LLC; Drexel Surgery Center, LLC; and Froedtert Surgery Center, LLC. The term "Affiliate" in this Agreement includes MCW and the Froedtert Health affiliate organizations listed above.

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1. **Notice of Privacy Practices:** I have received the Joint Notice of Privacy Practices which provides information about how the Affiliate may use and disclose Protected Health Information (PHI) about the patient. Signing this Agreement acknowledges the patient's receipt of the privacy practices. As provided in the notice, the terms of the notice may change. If the Affiliate changes the notice, the patient may obtain a revised copy by stopping at our Admitting Department/ Reception Desk or visiting our website at *froedtert.com*.
2. **Medical Consent:** My signature below provides consent for the full duration of this Agreement to medical care and treatment as deemed necessary and proper by the authorized medical providers of the Affiliate for the patient identified below. I understand that the patient is under the direct care of providers while at an Affiliate location and I expect the providers of the Affiliate to carry out their instructions. This Agreement also includes consent for any Affiliate services rendered under the general or special instructions of a provider, including, but not limited to, X-ray examinations, laboratory procedures, medical or surgical treatments and administration of anesthesia. I understand that some of the providers are independent contractors and not employees of the Affiliate.

   I acknowledge that any medical care furnished to the patient in the Emergency Department will be limited solely to emergency treatment. I understand that the patient may be released before all of the patient's medical problems are known or treated, and that it will be necessary for the patient to arrange follow-up care.
3. **Consent to Record, Photograph or Film:** I consent to the recording, photographing, closed circuit monitoring or filming of the patient for purposes of treatment (will be in the medical record) or for the organization's internal operations (not in the medical record) such as quality of care and teaching.
4. **Student Participation:** I understand that the Affiliate has educational programs and affiliations with academic institutions and I agree to student and resident participation in the patient's care under appropriate supervision.
5. **Financial Agreement and Assignment:** I, the undersigned agree, whether signing as agent or as patient, that I am financially responsible for all charges incurred. Assignment of commercial insurance benefits to the Affiliate does not reduce the responsibility for payment. Should the account be referred to any attorney for collection, the undersigned shall also be responsible for reasonable attorney's fees and any additional fees associated with the collection process. Further, by signing below, I authorize payment to be made directly to the Affiliate for the benefits otherwise payable to me by any third party including major medical benefits. I understand that a service fee may be charged for the processing of any uncollectible check presented as payment for goods/services provided by an Affiliate. I agree to pay the Affiliate the patient responsibility, including co-insurance and deductibles, not covered by the patient's insurance, subject to applicable Medicare and Medicaid advance notice requirements.

READ BACK PAGE FOR FURTHER INFORMATION.

_____ Date:____/____/_____ Time:_____ ☐ AM ☐ PM

Signature of patient, closest relative, legal guardian, or other authorized person

_____ Date:____/____/_____ Time:_____ ☐ AM ☐ PM

Signature of Witness

NOTE: If this document is signed by someone other than the patient, complete either A, or B. If a verbal consent is obtained, complete C, whichever applies:

A. The patient is a minor.

B. The patient is unable to consent because: _____

C. Verbal consent received due to: _____

_____ Date:____/____/_____ Time:_____ ☐ AM ☐ PM

Signature of Additional Witness

FH Affiliate Agreement - Yearly = 100435

Affiliate Conditions of Admission and/or Treatment Agreement- Yearly - Item # 37988

ORIGINAL - Medical Records
CANARY - Patient

11/18

Froedtert & Medical College of Wisconsin
9200 West Wisconsin Avenue
P.O. Box 26099
Milwaukee, WI 53226-3596

6. **Medical Claims**: I request that payment of authorized Medicare benefits, if applicable, and any Medigap Supplemental Insurance benefits identified by me and provided to or on file with the Affiliate on this date, be made either to me or on my behalf to the Affiliate for any services furnished me by that provider. I authorize any holder of medical information about me to release to Medicare, its agents, and Medigap Supplemental Insurance identified by me, any information needed to determine these benefits or the benefits payable for related services. The authorization contained in this paragraph remains in effect until the date specified for the expiration of this Agreement unless I revoke it sooner or unless I become an inpatient, at which time I will sign a new authorization.

7. **Intent to Donate Unclaimed Patient Refunds:** Occasionally a patient is owed a refund. It is the Affiliate's policy to refund all amounts due to patients. However, if you are owed a refund and the Affiliate is unable to locate you (or your estate) at your last-known address, the Affiliate may ultimately be required to turn over the refund to the Treasurer of the State of Wisconsin pursuant to the laws governing unclaimed property. If the monies remain unclaimed, the State Treasurer will deposit them in the State school fund. Alternatively, a patient may designate that refunds that are not claimed are donated as a gift to the Affiliate. By signing below, I agree that if I am owed a refund and the Affiliate is unable to locate me at my last-known address within one year of the discovery of the refund due, or if the refund amount owed me is less than $20.00, I hereby donate the refund to the Affiliate, at the Affiliate's discretion.

8. **Disclosure of Confidential Information:** To the extent necessary to determine liability for payment and to obtain reimbursement, I hereby authorize the Affiliate to disclose information, including portions or all of my medical record, to any person or public or private funding sources providing health care insurance or reimbursement to or on behalf of the patient (including, but not limited to, Medicare, Medicaid, or other insurance). I understand the specific type of information to be disclosed includes diagnosis, prognosis, and treatment for physical illness, and, where applicable - mental illness, developmental disabilities, HIV test results or AIDS or any AIDS-related diagnosis, alcoholism or drug abuse for the purpose of enabling such evaluation or treatment to be performed.

9. **Personal Valuables:** Currency, watches, rings, necklaces, wallets, credit cards and other personal valuables should be retained outside the Affiliate's facility. Upon admission as an inpatient, if no one can retain such items outside the hospital, the patient may request to store items in the Affiliate's safe. A special waiver form must be signed by the patient before the Affiliate accepts such valuables and before the patient is admitted to the unit. I understand that the patient will be responsible for all articles kept in the patient's room, that the Affiliate assumes no control over personal valuables not deposited in its safe. I understand and agree that the Affiliate assumes no responsibility to reimburse for any loss or damage to money, jewelry, glasses, dentures, personal clothing or other articles brought by or for me to the Affiliate. I understand that the Affiliate maintains a safe for the storage of valuables and other articles during inpatient hospitalization that I may utilize upon request.

10. **No Smoking, Unauthorized Weapons or Firearms Policy:** I understand that no smoking, or unauthorized weapons or firearms are permitted anywhere in the Affiliate buildings and/or the grounds. I understand that a patient who leaves the building to smoke does so at the patient's own risk and is solely responsible for any and all adverse effects that may occur.

11. **Ongoing Care Needs:** At the time of admission/registration, it is important to start considering and planning for any care that might be required after discharge and/or after leaving the clinic. I understand that I have the freedom to choose and the right to select my provider for post-discharge and post clinic care. I am aware that for home health care and hospice services after discharge, the hospital will generally recommend Horizon Home Care and Hospice (an affiliate of the hospital), Froedtert & the Medical College of Wisconsin Home Infusion, or another affiliate of the hospital, unless I select a different provider. I understand that I will receive a list of other available home care agencies when specific discharge plans are discussed, and that I may ask a nurse/case manager for the list at any time.

12. **Notice Regarding Patient Health Care Records:** I acknowledge that upon submitting a valid, written authorization, I may inspect and/or receive a copy of my health care records, including radiology reports, at my own expense. The review shall take place in the Affiliate's Health Information Management (HIM) Department during regular business hours, upon reasonable notice. I am aware that I may authorize other persons to review and receive a copy of my medical records by signing a valid authorization form. An Authorization form that complies with the legal requirements can be obtained from the Affiliate's HIM Department.

13. **Contact Made Via Telephone:** I authorize Froedtert Health and its Affiliates or contractors to contact me for any purpose, including appointment reminder calls or calls for payment of services, at the current or any future numbers that I provide for my landline telephone, cellular telephone or any wireless device, including the use of automated dialing equipment or prerecorded voice or text messages.