BON SECOURS MERCY HEALTH

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Dear Parent/Guardian,

Welcome to our practice and thank you for choosing Bon Secours Pediatric Dental Associates! We look forward to teaching your child the importance of forming healthy dental habits that will last a lifetime.

During your initial visit, we will review your child's medical and dental history and address any concerns you have about your child's teeth. If your child is ready, we will clean their teeth and apply a topical fluoride varnish. We will also demonstrate effective brushing and flossing techniques for your child. One of our dentists will examine your child and may recommend digital radiographs. The dentist will then discuss any findings with you along with any treatment recommendations.

We understand that most parents are nervous about how their child is going to react at his or her first dental visit. Our goal is for all of our new patients to have a fun, exciting, interesting, and educational visit. We are committed to providing the most positive dental experience we can for your child. This is your child's first visit to our office and we want it to be an awesome one.

To prepare you and your child for the visit please follow the link http://bsrkidsdentistry.com/appointments/forms/ to print and complete the new patient forms. You can bring the completed forms with you to your appointment, fax them to our office at (804)285-1292, or email them to our secure email at pedsdental@bshsi.org. **If you have not filled out the new patient paperwork, please arrive at least 20 minutes prior to your appointment to fill it out so that you will be called back on time to see the doctor.** For the initial appointment, the parent or legal guardian MUST be present at this visit, therefore, please bring your photo ID, insurance card and custody paperwork (if applicable). After the first visit, you may add family/friends to your child's PHI form giving them authorization to bring the child to an appointment.

For patients with private insurance, our doctors recommend having fluoride treatment done at both of the routine cleaning visits each year. Most private insurance companies cover the fluoride application once a year; therefore, the second application would be an out of pocket expense to the patient/guarantor. Please verify with your insurance company whether you will need to pay out of pocket for the fluoride at your next visit. You do have the option of opting out of the fluoride, but this is something that all of our doctors recommend.

Attendance: Please note that in a rolling 12 month period of time 3 missed appointments could result in dismissal.

- First Missed Appt – you will receive a call to notify you that you have missed your appt.
- Second Missed Appt – you will receive a call to notify you that it is your second missed appt.
- Third Missed Appt – you will be sent a dismissal letter

As a courtesy, if you arrive late to your appointments, we will try to accommodate you with another available time on our schedule that day; If there is no open time available, we will be happy to reschedule you to our next available time on another day.

We are looking forward to seeing: _____

Initial and Date:_____

Bon Secours
Medical Group

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

PRACTICE NAME: _____

PATIENT INFORMATION

PATIENT NAME: _____
Last First Middle

HOME ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

MAILING ADDRESS: (☐ same as above) _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE: (____)_____ WORK PHONE: (____)_____ CELL PHONE: (____)_____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: _____ CONTACT PREFERENCE: _____

GENDER: _____ RACE: _____ ETHNICITY: _____

LANGUAGE: _____ RELIGIOUS PREFERENCE: _____

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

EMPLOYER: _____ PHONE #: (____)_____

EMAIL: _____ ☐ No E-Mail ☐ Declines to Provide

HOW DID YOU HEAR ABOUT US? _____

GUARANTOR INFORMATION *(name of person to whom financial statements are sent)*

GUARANTOR NAME: _____
Last First Middle

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (____)_____ DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

INSURANCE POLICY INFORMATION

PATIENT RELATIONSHIP TO POLICY HOLDER: (circle one) SELF SPOUSE CHILD OTHER

PRIMARY POLICY HOLDER DATE OF BIRTH: _____

SECONDARY PATIENT RELATIONSHIP TO POLICY HOLDER: (circle one) SELF SPOUSE CHILD OTHER

SECONDARY POLICY HOLDER DATE OF BIRTH: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP: _____

HOME PHONE: (____)_____ CELL PHONE: (____)_____

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE: _____ DATE: _____

BON SECOURS MEDICAL GROUP

Initial History Questionnaire

FORM COMPLETED BY

DATE COMPLETED

Name

ID NUMBER

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live.

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

Birth History

Birth weight

Was the baby born at term? Early? Late?

If early, how many weeks' gestation?

Did mother have any illness or problem with her pregnancy?

☐ Yes ☐ No Explain

During pregnancy, did mother:

Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No

What When

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why?

Did your baby have any problems right after birth?

☐ Yes ☐ No Explain

Was initial feeding ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain

General

Do you consider your child to be in good health?	☐ Yes	☐ No	Explain
Does your child have any serious illness or medical condition?	☐ Yes	☐ No	Explain
Has your child had serious injuries or accidents?	☐ Yes	☐ No	Explain
Has your child had any surgery?	☐ Yes	☐ No	Explain
Has your child ever been hospitalized?	☐ Yes	☐ No	Explain
Is your child allergic to any medicines or drugs?	☐ Yes	☐ No	Explain
Is your child taking any medications currently?	☐ Yes	☐ No	List Medications

Development

Are you concerned about your child's physical development?	☐ Yes	☐ No	Explain
Are you concerned about your child 's mental or emotional development?	☐ Yes	☐ No	Explain
Are you concerned about your child's attention span?	☐ Yes	☐ No	Explain

If your child is in school:

How is his/her behavior in school?

Has he/she failed or repeated a grade in school?

How is he/she doing in academic subjects?

Is he/she in special or resource classes?

Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who_____	Comments_____
Nasal allergies	☐ Yes	☐ No	Who_____	Comments_____
Asthma	☐ Yes	☐ No	Who_____	Comments_____
Eczema	☐ Yes	☐ No	Who_____	Comments_____
Tuberculosis	☐ Yes	☐ No	Who_____	Comments_____
Heart disease (before 50 years old)	☐ Yes	☐ No	Who_____	Comments_____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who_____	Comments_____
High cholesterol	☐ Yes	☐ No	Who_____	Comments_____
Anemia	☐ Yes	☐ No	Who_____	Comments_____
Bleeding disorder	☐ Yes	☐ No	Who_____	Comments_____
Liver disease	☐ Yes	☐ No	Who_____	Comments_____
Kidney disease	☐ Yes	☐ No	Who_____	Comments_____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who_____	Comments_____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	Who_____	Comments_____
Epilepsy or convulsions	☐ Yes	☐ No	Who_____	Comments_____
Alcohol abuse	☐ Yes	☐ No	Who_____	Comments_____
Drug abuse	☐ Yes	☐ No	Who_____	Comments_____
Mental illness	☐ Yes	☐ No	Who_____	Comments_____
Mental retardation	☐ Yes	☐ No	Who_____	Comments_____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who_____	Comments_____
Cancer and type	☐ Yes	☐ No	Who_____	Comments_____

Additional family history _____

_____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When_____
Frequent ear infections	☐ Yes	☐ No	Explain_____
Problems with ears or hearing	☐ Yes	☐ No	Explain_____
Nasal allergies	☐ Yes	☐ No	Explain_____
Problems with eyes or vision	☐ Yes	☐ No	Explain_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain
Any heart problem or heart murmur	☐ Yes	☐ No	Explain_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain_____
Blood transfusion	☐ Yes	☐ No	Explain_____
Frequent abdominal pain	☐ Yes	☐ No	Explain_____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain_____
Bladder or kidney infection	☐ Yes	☐ No	Explain_____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain_____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	Explain_____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain_____
Any chronic or recurrent skin problem (acne, eczema, etc.)	☐ Yes	☐ No	Explain_____
Frequent headaches			
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain_____
Diabetes	☐ Yes	☐ No	Explain_____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain_____
Any other significant problem	☐ Yes	☐ No	Explain_____
Use of alcohol or drugs	☐ Yes	☐ No	Explain_____

Does the patient have any medical issues related to the following systems?

System	Yes/No	Detail	Treatment
Weight (Eating)			
Height (Growing)			
Eyes			
Ears			
Stomach/Bowels/Vomiting			
Mouth/Dental/Vomiting			
Heart			
Kidney/Urinary			
Skin/Rashes			
Allergies			
Breathing			
Hormonal Issues			
Blood/Bleeding Disorders			
Depression/Nervous Disorders			
Others Not Listed			

Dental Health History

YES NO

- ☐ ☐ Does your child have a dental condition about which you are especially concerned?
  If yes, please explain_____
- ☐ ☐ Is this your child's first visit to the dentist? If not, date of last dental care?_____
- ☐ ☐ Has your child ever received injuries to the head, jaw, mouth or teeth?
  If yes, describe_____
- ☐ ☐ Does your child have a toothache?
- ☐ ☐ Was your child a thumb/finger sucker? Age discontinued?_____
- ☐ ☐ Did your child use a pacifier? Age discontinued?_____
- ☐ ☐ Was your child bottle-fed? Age discontinued?_____
- ☐ ☐ Was you child breast-fed? Age discontinued?_____
- ☐ ☐ Is your child a mouth breather?
- ☐ ☐ Does your child grind or clench his/her teeth?
- ☐ ☐ Do you child's gums bleed?
- ☐ ☐ Is your child presently taking a flouride supplement? If so, what?_____
- ☐ ☐ What is your water source? Public System_____ Private Well_____ Reverse Osmosis System_____
- ☐ ☐ How often are your child's teeth brushed per day?_____ By who?_____ What type of toothpaste?_____

I certify that I have read and understand the above questions.

Signature of Parent or Legal Guardian _____ Relationship to patient _____ Witness _____ Date _____

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I, _____give my permission to Bon Secours Pediatric Dental Associates to send update letters about my child, _____'s dental care and conditions to his/her primary care physician to keep in compliance with patient centered medical-dental home.

_____ _____

Primary Care Physician Telephone Number

_____ _____

Parent/Guardian Signature Date

BON SECOURS MERCY HEALTH

BSMH Patient Agreement

This agreement cannot be modified. Any handwritten changes shall not be legally binding or enforceable.

This BSMH Patient Agreement ("Agreement") applies to services rendered at or through all Bon Secours Mercy Health, Inc.-owned or affiliated entities in the United States, including hospitals, physician and provider offices, ambulatory surgery centers, laboratories, telehealth programs, clinics, urgent care centers, freestanding emergency departments, imaging centers and other health care facilities (together, "BSMH"). A list of those entities is located at https://www.bonsecours.com/patient-resources/your-privacy-and-hipaa and at https://www.mercy.com/patient-resources/your-privacy-and-hipaa and each may be updated from time to time.

Consent to Medical Examination, Care & Treatment; Telehealth: I acknowledge that I am seeking medical care, a health care screening and/or other appropriate treatment to be rendered through one or more health care providers employed by or affiliated with BSMH. I voluntarily consent to and authorize the following, as applicable: (i) a physical and/or mental examination; (ii) administration of diagnostic procedures; (iii) rendering of medical care and treatment to me; (iv) laboratory testing; (v) toxicology screening; (vi) radiological procedures; (vii) administration of medications; (viii) follow-up care; (ix) education on my health condition; and (x) all other related care and treatment, as is deemed necessary and advisable by my health care provider(s) with BSMH (together, "Care"). I understand that there are risks of injury from Care. I understand that the practice of medicine is not an exact science, and that no guarantees have been made to me about the results or outcomes of my Care. I understand that I may request additional information regarding any recommended Care and that BSMH, or health care providers with BSMH, may obtain additional written consent from me for more complex Care, such as surgery. I understand that BSMH may adopt modified operations during a period of crisis or emergency made necessary by a pervasive (such as a pandemic) or catastrophic (such as a hurricane or tornado) disaster.

I understand that I may receive Care from BSMH on an in-person basis or through an electronic virtual platform that is generally referred to as "Telehealth." Telehealth involves the delivery of Care using electronic communications, information technology and/or other means (such as a wearable monitor) between a health care provider and a patient who are not located in the same place at the time Care is being provided.

I understand that in the case of Care provided in-person and provided via Telehealth, while there are benefits, there are also some risks, including, but not limited to: (a) my health care provider may advise me to seek urgent or emergency care services; (b) my health care provider may determine I need to be examined in person and may recommend – possibly after consulting with another clinician – that I may need to seek Care from a specialist or other healthcare provider; (c) my health care provider may be able to provide preliminary diagnose and treatment; however, to complete a diagnosis, I may be advised to obtain follow up Care, including an in-person visit; and (d) given regulatory requirements in certain jurisdictions, my health care provider's ability to prescribe certain Care options (e.g., certain controlled substance prescriptions) may be limited. Further, I acknowledge that the electronic systems or other security protocols or safeguards used in Telehealth could fail, which could expose my health and/or other personal information to unauthorized individuals, even if BSMH uses HIPAA-compliant, secure technology platform(s). I understand my connection with my health care provider may fail and we may have to re-engage in the encounter. I understand my Telehealth visit will not be recorded without my express consent. I understand that I can opt out of a Telehealth visit in favor of an in-person visit and that I may request information regarding my Telehealth provider's credentials, training and qualifications.

Medical Education Programs: I acknowledge that among those who attend to my Care at BSMH may be health care personnel who are currently in professional education or training programs, including: medical students, physician residents, nursing students, etc. All students and resident physicians are supervised by licensed and trained health care providers, as appropriate, and I consent to Care provided by them. Unless otherwise requested by me, these students and resident physicians may be present and participate in my Care as a part of their education or training.

Affiliated Providers/Independent Contractors/Non-Employed Providers: I understand that many of the health care providers with BSMH, possibly including my attending and/or consulting physicians, are not employees or agents of BSMH but, rather, are independent contractors who have been granted the privilege of using one or more BSMH locations for the Care of patients. I understand that the actions or inactions of any health care provider who is not an agent or employee of BSMH is not directed or controlled by BSMH and that BSMH relies upon such health care provider(s) to use appropriate professional judgment in providing Care to me at BSMH. I agree that BSMH is not responsible for the acts or omissions of any health care provider who is not an agent or employee of BSMH.

Affiliated Provider Fees: I understand that BSMH's hospital and facility charges for my Care may not include the fees

of health care providers who provided Care to me but who are not agents or employees of BSMH. I understand that I may receive a separate bill for my Care directly from such provider(s), including but not limited to, emergency department physicians, radiologists, pathologists, anesthesiologists, hospitalists, other specialists, etc. I understand that the level of insurance benefits payable for Care by health care providers who are not agents or employees of BSMH may be different from the level of insurance benefits payable for Care rendered through BSMH.

Left Without Being Seen; Non-Compliance with Care Plan: If I leave BSMH before a health care provider with BSMH has seen me or discharged me, or if I refuse to comply with my prescribed plan of care, I agree that I assume the full responsibility for this action and hold BSMH, its employees, and agents separately and individually harmless from any and all liability or harm as a direct or indirect result of my failure to be treated, my refusal to comply, and/or my departure from BSMH, and I will waive any and all rights and causes of action that I may now have or later acquire against BSMH, its employees, and agents as a direct or indirect result of any of the foregoing.

Uses/Access/Disclosure of My Health Information: I authorize BSMH, its duly authorized agents and affiliates to use and to disclose my individually identifiable information, including information about my Care, with other health care providers and facilities, both at BSMH and outside BSMH, who are involved in my Care, including for the purpose of coordinating my Care. I authorize BSMH to release my individually identifiable information, including information about my Care located in my BSMH-designated medical record about Care provided to me by BSMH and providers outside BSMH, and other financial and demographic information as required to obtain payment from my insurance or other payer(s) and their agents. I have been provided and/or offered a copy of the BSMH Notice of Privacy Practices which may be updated from time to time on BSMH's websites. I understand that this Notice of Privacy Practices outlines additional, authorized uses and disclosures of my health information by BSMH, as well as my rights to obtain my health information and to further restrict its use or disclosure.

Photography & Video Recordings: I consent to have my photograph taken by BSMH for purposes of confirming identification and for the treatment, payment and health care operations of BSMH. I understand that my Care at BSMH may include obtaining, using, and disclosing photographs, videos, and/or making audio recordings of me for Care-oriented purposes and/or for the health care operations of BSMH, including quality assurance, clinical documentation, education, or other purposes permitted by applicable law. To the extent that any such photography, video, and/or audio recording is included in my BSMH-designated medical record, I understand that BSMH will treat it as protected health information consistent with applicable law. *Notwithstanding the foregoing, I understand that I have the option at any time to decline to be photographed or videoed.*

Communications: I authorize BSMH, its agents and contractors (e.g., a billing company) to communicate with me directly by phone or by e-mail, text message and/or other forms of electronic communication that may be encrypted (together, "Electronic Messaging"). I understand that these authorized individuals will communicate with me using the phone number(s) and email(s) that I provide to BSMH. *Notwithstanding the foregoing, I understand that, at any time, I can direct BSMH to discontinue any or all Electronic Messaging by communicating my preferences to BSMH.* I further understand that withdrawing this authorization will not cause me to lose any benefits or rights to which I am otherwise entitled, including but not limited to, continued Care, payment options, enrollment or eligibility for programs/benefits offered by BSMH, etc.

I understand that authorized individuals may use Electronic Messaging to communicate with me regarding a wide range of healthcare-related issues, including: reminders of appointments; actions for me to take before an appointment; follow-ups from appointments; notices about preventive services, Care options, coordination of my Care and other available health care services; how to participate in patient satisfaction surveys; how to use BSMH's secure patient portal (MyChart); information regarding insurance, billing, eligibility for programs/benefits and account balances, etc. I understand that BSMH may use automatic dialers or pre-recorded voice messages when it communicates with me through Electronic Messaging.

I understand that BSMH cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of Electronic Messaging. I consent to the use of Electronic Messaging upon the following conditions: (1) **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911**; (2) Urgent messages or needs should be relayed to BSMH by telephone call; (3) Non-urgent messages or needs should be relayed to BSMH by telephone call or BSMH's secure patient portal, MyChart; (4) Electronic Messaging may be made a part of my BSMH-designated medical record; (5) BSMH, its employees, and agents are not liable to me for any breach of confidentiality caused by me or any third party; and

(6) I am solely responsible for any charges or other fees incurred under my agreement with my Electronic Messaging service provider (e.g., per minute, per message, per unit-of-data-received basis, etc.).

In consideration of BSMH's services and my authorization to receive Electronic Messaging as described in this Agreement, I release BSMH, its employees and agents from any and all claims resulting directly or indirectly from the Electronic Messaging, including any claims based on any alleged violation of applicable law (including the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, any federal or state tort or consumer protection laws, etc.).

Responsibility for Payment; Emergency Care: I understand that a list of BSMH's usual and customary charges for its health care services is available to me upon request. If I choose to pay for certain of these services out-of-pocket (i.e., self-pay) for the purpose of exercising my right to limit disclosure of my health information to my health insurer regarding those services, I understand that a separate financial agreement will be required regarding the self-pay services.

If I present to a BSMH emergency department seeking, or in need of, emergency medical treatment, I understand that screening and stabilizing treatment for any emergency medical condition will not be delayed or conditioned upon my ability to pay, method of payment, or my coverage status.

I understand that I am responsible for any amounts due for my Care that are not paid by my health insurer or any other applicable insurance plan, policy, or third party. Such amounts due may include, but are not limited to, deductibles, copays, and coinsurance amounts provided under any coverage source, charges for which there is no coverage source, etc. I understand and agree that I am ultimately responsible for any cost of my Care that is not covered by my insurance or other third party. I understand that I am responsible for any unpaid balances due, plus the reasonable costs of collections, including any attorney fees and court costs associated with collecting an unpaid portion of the bill.

Financial Agreements; Insurers & Third-Party Payers; Assignment of Benefits; Authorized Representative; Agent: If applicable, I certify that any information given by me in applying for payment under the Medicare or Medicaid Programs is correct. I assign to BSMH all rights to benefits, covered payments, insurance reimbursements or other payments to which I may be entitled for Care provided to me at BSMH. I authorize BSMH to bill my insurance or any other responsible party(ies) and assign the payment of these benefits directly to BSMH.

I assign all rights to benefits, insurance payments, insurance reimbursements or other payments or judgments to which I may be entitled for hospital-based physician Care (pathology, radiology, cardiology, etc.) and emergency department Care to the physician or organization providing the professional Care. I also authorize submission of a bill(s) for professional Care provided to me through BSMH to my insurance or any other responsible party(ies) for payment.

I authorize and designate BSMH (including any third parties who perform retrospective reviews, denial and audit work) as my authorized agent(s) and designated representative(s) with the power to act on my behalf with respect to all matters related to all of my rights, benefits, privileges, protections, claims, causes of action, interests or recovery arising out of any coverage source, including but not limited to, the ability to request reconsideration and/or appeal payment decisions made by any group health plan, employee benefits plan, health insurance plan, any other applicable insurance plan or utilization review entity for coverage or grievance review (the "Plan"), etc. This includes, without limitation, the authority and right to: file medical claims with the Plan; file appeals and grievances with the Plan; request verification of coverage or pre-certification or authorization; file pre-service and post-service claims; request any and all information and documents under which the Plan is established or operated; request any and all policies, procedures and guidelines and protocols considered by the Plan in connection with the benefit claim determination; and to institute any alternative dispute proceedings, litigation and/or complaints against the Plan naming me as the plaintiff in such proceedings if necessary. I further designate and authorize BSMH to the fullest extent permissible under law the right and ability to act as my representative with respect to any ERISA-governed benefit plans as provided in federal regulations with respect to any healthcare expense incurred as a result of the Care I received at BSMH. This authorization is applicable in the same manner as the other grants of authority conveyed within this paragraph, but I recognize they may be brought pursuant to federal ERISA regulations and case law. Similar to the provision in this paragraph, I recognize BSMH may assert any rights I may have under the plan even to name me as a plaintiff in an action against the plan. I understand I can revoke this authorization in writing at any time.

I acknowledge that BSMH reserves the right to file a lien where appropriate and permitted by applicable law.

I understand that if BSMH is not in contract with my plan or other coverage, there will likely be a balance due to me that is in excess of any co-pays, co-insurance or deductibles. I also agree that any attempt by a benefits coverage source to preclude BSMH from the ability to appeal a claim, to prevent balance billing if allowable by applicable law, or to disallow BSMH's right to take action by assignment, will not be acknowledged.

Although I previously acknowledged that BSMH reserves the right to receive payment from all applicable sources, I specifically authorize BSMH to pursue any and all applicable insurance(s) covering motor vehicle accidents as well as workers' compensation claims, and I agree to cooperate with BSMH by providing information and by completing any form(s) that BSMH may ask me to execute from time to time.

Finally, I understand that a health care provider with BSMH may order services, testing, items, or other Care that require pre-approval from my insurer or third-party payer before I receive such services, testing, items, and/or other Care. I agree to cooperate, aid and assist BSMH in obtaining all such approvals and possible insurance or other benefits for such services, testing, items, and/or Care (e.g., completing an application for insurance, providing timely information as requested, etc.).

Credit Balance Transfer: When a non-governmental credit balance exists on a BSMH account in an amount not exceeding $10.00, I agree that BSMH may adjust that balance to zero without investigation for overpayment, or improper/excess payment made to a practice/provider as a result of patient billing, or claims processing errors.

Pharmacy Benefit Programs: I understand that if I cannot afford medication prescribed to me during my Care at BSMH, or if that medication is not covered by my insurance, BSMH may be able to obtain reimbursement for certain medications through one or more Patient Assistance Programs sponsored by drug manufacturers. To qualify for the Program(s), it may be necessary to provide information regarding my financial status, illness, and/or treatment to the drug manufacturer sponsoring the Program(s). All information associated with these Programs will remain confidential and will only be provided to drug manufacturers in compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable law. My signature on this form authorizes BSMH and its authorized representatives to complete any necessary application forms. I release any claim to the medication I may receive as a result of my participation in the Program(s) and give my permission for any medication to be repackaged. This authorization shall remain in full force from the date signed, below, until I revoke it or until I no longer belong to any Programs, whichever occurs earlier.

BSMH Packet of Patient Information: I understand that BSMH offers Financial Assistance to those that meet certain eligibility criteria outlined in BSMH's Healthcare Financial Assistance ("HFA") Policy and that a copy of the Plain Language Summary of BSMH's HFA Policy is available upon request. I confirm that I am aware of the HFA Policy and that a copy of the Plain Language Summary has been offered to me. I agree that if I make an application for this Financial Assistance, BSMH is permitted to request, use, and disclose information as necessary to determine whether I am eligible for Financial Assistance.

I agree to comply with all guidelines, policies and procedures I may receive from BSMH at the time of my Care. I understand that information on BSMH's HFA Policy and its Plain Language Summary enumerate certain rights afforded to me as a patient and are consistent with the BSMH Code of Conduct. I acknowledge that I have received other documentation required by law in my packet of patient information, including Patient Rights & Responsibilities documentation, if appropriate.

Responsibility for Valuables/Personal Property: I understand and agree that BSMH is not responsible for safeguarding my personal property or any other personal item. I agree to waive any and all rights and causes of action that I may now have or later acquire against BSMH, its employees, and agents as a direct or indirect result of any loss, theft, or damage to such property or item, including: jewelry, clothing, money, hearing aids, glasses, dentures, dental work, electronics, vehicles, etc. BSMH recommends that I leave my valuables at home or with a family member or friend.

Statement of Non-Discrimination: BSMH complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, ethnicity, religion, sex or sexual identification, national origin, sexual orientation, age, ancestry, disability, veteran era status, or any person with HIV infection, whether asymptomatic or symptomatic, or AIDS, in any other manner prohibited by applicable State or Federal law, or in the treatment of patients. BSMH does not exclude people or treat them differently because of race, color, ethnicity, religion, sex, national origin, sexual orientation, age, ancestry, disability, veteran

era status, or any person with HIV infection, whether asymptomatic or symptomatic, or AIDS, or in any other manner prohibited by applicable State or Federal law.

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BY SIGNING BELOW, I CONFIRM ALL THE FOLLOWING: I have read this Agreement or have had it effectively communicated to me; any questions I may have had about this Agreement have been asked and answered to my satisfaction; I acknowledge that a separate consent or agreement may be required prior to receiving certain Care with BSMH; I understand and accept all the terms and conditions of this Agreement; I am the patient or his/her duly authorized personal representative; and I am signing this Agreement voluntarily.

_____	**OR**	_____
Signature of Patient		Signature of Personal Representative
Date & Time: _____		Date & Time: _____
_____		_____
Patient Printed Name		Personal Representative Printed Name

BON SECOURS MERCY HEALTH

PLAIN LANGUAGE SUMMARY OF HEALTHCARE FINANCIAL ASSISTANCE POLICY

Overview

In with the light of its mission to improve the health of its communities, with special emphasis on the poor and underserved, and in the spirit of the healing ministry of Jesus, Bon Secours Mercy Health is committed to providing financial assistance to its patients. This is a summary of the Bon Secours Mercy Health Healthcare Financial Assistance (HFA) Policy.

Availability of Financial Assistance

Eligibility for financial assistance is determined by the ability of the patient or his/her guarantor to pay after all available resources have been utilized and all available assistance programs have been assessed. Financial assistance is available for emergency and other medically necessary care provided by Bon Secours Mercy Health hospitals (and certain other providers) to uninsured and underinsured patients who live in the community served by a Bon Secours Mercy Health hospital, and whose family income does not exceed four times the Federal Poverty Guidelines (FPG).

Eligibility Requirements

Financial assistance is generally determined by a sliding scale of total household income based on the FPG. Individuals eligible for financial assistance under our Policy with an income level at 200% FPG or below receive free care. Individuals with an income level from 201% to 300% FPG, and 301% to 400% FPG, respectively, receive discounted care based on a sliding scale, as set forth in the Policy. The specific percentage discounts for the 201%-300% FPG, and 301% to 400% FPG, income levels are updated annually for each market commensurate with changes in the charge master.

No person eligible for financial assistance under the HFA policy will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care. If an individual has sufficient insurance coverage or assets available to pay for care, he/she may be deemed ineligible for financial assistance. For those uninsured patients who do not qualify for any of the financial assistance discounts described in the HFA policy, Bon Secours Mercy Health extends an automatic (selfpay) discount to their hospital bills. Please refer to the full HFA Policy for a complete explanation.

About the Application Process

The process for applying for financial assistance under our HFA Policy includes these steps:

- Complete the HFA Application Form and include required supporting documents.
    - We look at your income and family size to determine the level of assistance available to you. We use a sliding scale, based on FPG outlined above.
    - We require that you must first explore eligibility for some type of insurance benefits that would cover your care (i.e. worker's compensation, automobile insurance, etc.) We can help direct you to the appropriate resources.
- We will contact you to tell you whether you are eligible for financial assistance under our HFA Policy.
- We can help you arrange a payment plan for any remaining charges or bills that are not covered under our HFA Policy.
    - A payment plan will consider your financial situation to set payments that you can manage.

Where to Obtain Information

You may obtain a copy of our HFA Policy and the HFA Application Form, as well as information about the financial assistance application process: (i) by visiting our website at www.bsmhealth.org/financial-assistance, www.mercy.com/financial-assistance, and www.fa.bonsecours.com, (ii) by contacting Bon Secours Mercy Health Patient Financial Services by telephone at 1-877-918-5400, (iii) by mailing a request to Bon Secours Mercy Health, 11511 Reed Hartmann Highway, Blue Ash, OH 45241, Attn: Financial Counseling, or (iv) by contacting our financial counselors in person at any of our hospital locations (see the full HFA Policy for a complete listing of facilities and addresses).

We accommodate all significant populations served by Bon Secours Mercy Health that have limited proficiency in English by translating copies of our HFA Policy, Application Form, and this Summary in the primary languages spoken by those populations. We may also elect to furnish translation aids, translation guides, or provide assistance through use of qualified bilingual interpreters.

BON SECOURS MERCY HEALTH

Language Interpreters

Bon Secours Mercy Health, Inc. ("BSMH") provides free aids and services to people with disabilities to communicate effectively with us such as:

- Qualified sign language interpreters
- Written information in other formats (large print, Braille, audio, accessible electronic formats, other formats)

You can contact the person at the registration desk to receive information on how to obtain the free aids and services for persons with disabilities or access the interpretation services.

All patients have access to interpretation services 24/7 at no personal cost to them.

- lHabla espanol? Le proporcionaremos un interprete sin costo alguno para usted. (Spanish)
- 您讲国语吗？我们将免费为您提供 翻译 (Mandarin)
- Sprechen Sie Deutsch? Wir stellen Ihnen unentgeltlich einen Dolmetscher zur Verfogung. (German)
- هل تتحدث اللغة العربية؟ سوف نوفر لك مترجمًا فوريًا بدون أي تكلفة عليك • (Arabic)
- Bbl l'OBOp1ne rro-pycCKH? Mbl a6comOTHO 6ecmraTHO rrpeJ:IOCTaBHM BaM rrepeBO,[(Y.HKa. (Russian)
- Parlez-vous fram;ais? Nous vous fournirons gratuitement un interprete. (French)
- Quy vi n6i duQ'c ti@ng Vi t kh6ng? Chung t6i se cung c p mot thong dich vien mi&n phi cho quy vi. (Vietnamese)
- 한국어를 사용하십니까? 무료로 통역 서비스를 제공해 드리겠습니다. (Korean)
- Parla italiano? Le forniremo gratuitamente un interprete. (Italian)
- 日本語を話しますか？ 個人的な負担なしで通訳を提供致します。 (Japanese)
- B11 pmMOBAAeTe yKpai:HChKOIO? M11 a6co11IOTHO 6e3KOIIITOBHO tta):(aMo BaM rrepeKJia):(aY.a. (Ukrainian)
- Vorbiti romane te? Va vom asigura gratis un interpret. (Romanian)

Complaints and Grievances

If you believe BSMH has failed to provide these services or discriminated in another way on the basis listed above, you can file a grievance. BSMH can provide a copy upon request of its grievance filing procedures and contact information for individual(s) who can assist in filing and addressing the grievance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509 F, HHH Bldg, Washington DC 20201 [1-800-368-1019 or 1-800-537-7697 {TDD}].

BON SECOURS MEDICAL GROUP
Bon Secours Richmond Health System

Permission to Disclose Private Health Information (PHI)

Patient Name: _____ DOB: _____

By signing this paper below, I give permission to the person(s) listed in the table documented to receive Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting by request to change, add, or terminate such permission in writing.

Date of Permission	Name of Individual	Comments/Instructions (i.e.; may pick up meds)	Parent/ Guardian Initials	Date Permission Revoked	Parent/ Guardian Initials	Telephone Number

In order to obtain information by telephone, the party calling the practice must be able to share the patient identifier/password with the staff.

Patient Identifier/Password: _____

Signature of Patient or Legal Guardian _____ Date _____ Time _____

Printed Name of Patient or Legal Guardian _____ Relationship (if not self) _____

Bon Secours
Medical Group

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

Practice Name: _____

Authorization for Treatment

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety.
- I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns before treatment is provided.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Virginia law.
- I understand that Bon Secours Health System utilizes an electronic medical record system.
- I understand that Bon Secours Health System utilizes an electronic prescribing mechanism for electronic transmission of prescriptions and that any medications my physician prescribes for me may be communicated electronically through any local or mail order pharmacy I have designated.
- I authorize the release of my prescription history to my Bon Secours Health System physician from any pharmacy or drug monitoring agency.

Payment Arrangements

- I agree to accept financial responsibility for the payment of the costs of health care services provided to me and my dependent(s) by or on behalf of Bon Secours Health System.
- By signing this document, I authorize the assignment to the Medical Practice of all payments under any insurance benefits otherwise payable to me for services provided under any insurance policy (hospitalization, major medical, workers' compensation, or any other insurance or benefit plan).
- I agree to pay, at the time of service, any required co-payments, co-insurance and deductibles, as well as charges for services provided by Bon Secours Health System which are not covered by my insurance.
- I understand that all unpaid balances will be billed to my address on file with this office and that I am responsible for updating my registration information as necessary.
- I understand that I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance.
- I understand that there is a $20 charge for any check returned by my bank.
- I understand that any past due amount owed on my account may be referred to a collection agency, and that I will be responsible for all collection charges and associated legal fees, in addition to the full balance on my account.
- By signing this document, I agree that photocopies of this document are as legally binding as the original.

This Authorization for Treatment is a legal document and no modifications may be made to it without the written approval of an authorized Bon Secours Health System employee. By signing below, I acknowledge that I have read, understand and agree to the above terms.

Patient or Guarantor Signature	Printed Name	Relationship to Patient	Date	Time

Patient Name: _____

DOB: _____

MR #: _____

Patient Email and Text Message Informed Consent

Bon Secours Health System, Inc. and its affiliates, agents, independent contractors and any "covered entity" or "business associate" (as those terms are defined in the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively, "Bon Secours") may communicate with you by e-mail, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Messaging") to the telephone number(s), email address(es) or other locations reflected on your account or as otherwise provided below. This form provides information about Bon Secours' use, risks, and conditions of Electronic Messaging. It also will be used to document your consent for Bon Secours' communication with you by Electronic Messaging.

How we will use Electronic Messaging: Bon Secours may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including:

- reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services;
- how to participate in patient satisfaction surveys or how to use our secure patient portal (MyChart); and
- information regarding insurance, billing, eligibility for programs/benefits, and account balances.

Bon Secours may use automatic dialers or pre-recorded voice messages when it communicates with you through Electronic Messaging. All Electronic Messaging may be made a part of your medical record.

Risk of using Electronic Messaging: Electronic Messaging has a number of risks that you should consider, including:

- Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
- Senders can easily misaddress Electronic Messaging and send the information to an unintended recipient.
- Backup copies of Electronic Messaging may exist even after deletion.
- Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection.
- Electronic Messaging service providers may charge for calls or messages received.
- Employers and online providers have a right to inspect Electronic Messaging sent through their company systems.
- Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: Bon Secours cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911.** Urgent messages or needs should be relayed to us by using regular telephone communication. Non-urgent messages or needs should be relayed to us by using regular telephone communication or our secure patient portal, MyChart.
- Electronic Messaging may be filed into your medical record.
- Bon Secours is not liable for breaches of confidentiality caused by you or any third party.
- You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: Unless you earlier withdraw your consent, this consent will expire upon the end of your treatment relationship with Bon Secours. You may choose to stop participating in Electronic Messaging at any time by informing Bon Secours in writing as described herein. You further understand that withdrawing this consent will not cause you to lose any benefits or rights to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility for benefits. To withdraw consent and stop participating in Electronic Messaging, please contact the BSHSI Privacy Officer or your Local Privacy Officer as described in the Notice of Privacy Practices.

Patient Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between Bon Secours and me, and I consent to the conditions and instructions outlined, as well as any other instructions that Bon Secours may impose to communicate with me by Electronic Messaging.

I understand that Bon Secours will send Electronic Messaging to those telephone number(s) and email address(es) in my account:

☐ I request to receive **text messages**

☐ I request to receive **e-mail messages**

Release. In consideration of Bon Secours' services and my request to receive Electronic Messaging as described herein, I hereby release Bon Secours from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

_____ _____ _____

Patient (or Authorized Representative) Signature **Patient's Printed Name** **Date**

804-893-8715

I, _____ give my permission to Bon Secours Pediatric Dental Associates to send update letters about my child, _____'s dental care and conditions to his/her primary care physician to keep in compliance with patient centered medical-dental home.

_____ _____

Primary Care Physician Telephone Number

_____ _____

Parent/Guardian Signature Date