Section A: Authorization for Diagnostic Procedures and Medical Treatment

PATIENT CONSENT AND AUTHORIZATION FOR TREATMENT

I. Consent: I, on behalf of myself or as an authorized person for any other individual, consent to all treatment recommended by my physician which may include emergency services or treatment, diagnostic testing, imaging and laboratory procedures, medical or surgical treatment, anesthesia, and other treatments recommended for me while a patient at Tampa General Hospital ("TGH"). These treatments may involve the risk of injury or death. I acknowledge that no one at TGH has made any guarantees to me regarding the treatments or care I may receive while at TGH.

II. Treatment at an Academic Medical Center: TGH, in conjunction with the University of South Florida ("USF") is an academic medical center, As a teaching and research facility, my treatment and care at TGH may be provided by USF medical students and residents under the supervision of a USF physician, or may be observed by others who are not licensed healthcare providers.

III. I acknowledge that TGH is not responsible for the medical care or treatment provided by USF physicians or any other independent contractor physicians. Most physicians who will treat me at TGH are notemployees or agents of TGH. I also understand that I have a right to choose the physician who directs my care, provided that the physician ofmy choice has appropriate privileges at TGH. I agree that I will be relying on my physicians and other healthcare providers, including medical students and residents and their employers ("Healthcare Providers") to provide me with appropriate care and treatment. I will not look to TGH to fulfill those duties or obligations. I hereby release TGH from any and all liability for the acts or omissions of any Healthcare Provider not employed by TGH.

IV. Research and Education: I understand while a patient at TGH, I may be contacted for the purposes of research and/or clinical educational settings; however, I am not obligated to participate in any research and/or agree to treatment in any clinical educational setting. I understand that photographs, videos and other images may be taken for identification, as part of or to document my care, or for educational purposes. I consent to the use of all my medical data and any non-identifiable photographs for educational and/or research purposes. I authorize TGH to retain, preserve and use for scientific, educational, commercial or research purposes, or to dispose of, any specimens, tissues or organs taken from my body during the course of treatment. I will not share in any proceeds that may generated therefrom.

V. Recordings. I understand that TGH utilizes video and audio recording technology to facilitate and enhance the patient care I will be provided. By signing below, I am agreeing to the use of such technology.

VI. Advance Directives: I have received information about the TGH's policy on Living Wills and the designation of a health care surrogate. Additional information on these subjects are available upon my request.

VII. Reporting Requirements: If my test results reveal a condition that is reportable to a government agency, including the local health department, by applicable Florida or federal law, TGH may release my personal contact information along with positive results to the applicable agencies as required by law.

VIII. Telemedicine and Telepsychiatry. I understand and agree that my providers may use telemedicine, including videoconferencing, electronic transmission of imaging, and remote monitoring of vital signs, as part of my Care. Except in emergencies, my providers will explain the risks and benefits of telemedicine prior to the encounter. I understand that I have the right to seek in-person Care instead of a telemedicine encounter.

IX. Tobacco Free Campus. TGH prohibits the use of tobacco products, electronic cigarettes, and vaping devices anywhere within the hospital or its campus. If I choose to engage in this prohibited activity, I understand I am removing myself from TGH's care and may be discharged. I assume all risks associated with this prohibited activity, which may include medical complications, injury, and/or death. I hereby release TGH from any and all liability associated with this prohibited activity.

X. Illegal Items. I will not bring any weapon, explosive device, illegal drug or substance, alcoholic beverage, or other contraband to TGH. If found in my or my guests' possession or control, TGH shall take any action it deems reasonable, including alerting the police, confiscating and disposing of any contraband items, which may be delivered to law enforcement, or excluding certain persons from TGH and its affiliated properties. You acknowledge that TGH may search any items brought into any part of the hospital, including a patient room, if TGH reasonably believes that potentially harmful contraband is present.

Section B:

ASSIGNMENT OF PROCEEDS, AUTHORIZATION TO RELEASE INFORMATION AND GUARANTOR AGREEMENT

I. Medicare/Medicare Advantage/Medicaid/TRICARE: I certify that the information given by me to apply for payment under any Title of the Social Security Act is correct. I also certify that I have complied, and will continue to comply, with all laws applicable to any such payments, including any obligation to protect the interests of the payors of any such payments as may be required or necessary. I authorize any holder of medical or other information about me to release to the Social Security Administration, and its intermediaries or carriers any information related to any claim. I request that payment of authorized benefits be made on my behalf to TGH or Healthcare Provider, as applicable, by any applicable payor. I assign the benefits payable for TGH or Healthcare Provider services to TGH or the Healthcare Provider furnishing the services (as applicable), and I authorize TGH or such Healthcare Provider to submit a claim to Medicare, Medicare Advantage, Medicaid or TRICARE for payment. I understand that I am responsible for any health insurance deductibles, co-insurance, co-payments, and all non- covered charges. TGH has provided me the Medicare notice entitled "An Important Message from Medicare," and I am personally responsible for any non-covered services, deductibles, co-payments and/or co-insurances.

II. Assignment of Insurance Benefits and Proceeds: I assign to TGH or the Healthcare Provider, as applicable, all of my rights and interests to any benefits or other recovery of any type whatsoever receivable by me or on my behalf that may be due and payable to me by any governmental payor, insurance company (including automobile liability, liability, personal injury protection, medical payments, uninsured or underinsured motor vehicle benefits), health maintenance organization, managed care company, self-funded plan, plan sponsor, plan fiduciary, and their agents (each, a "Health Plan") as well as from any settlements/judgments/verdicts, or any other third-party payor for any costs incurred in receiving healthcare goods or services from TGH or any Healthcare Provider (as applicable). I authorize direct payment to TGH and/or any Healthcare Provider (as applicable) of all such benefits or recovery. I authorize and designate TGH and/or the Healthcare Provider (as applicable) as my agent and authorized representative to pursue any appeal of any claim under this assignment, including to receive all information, documentation, and/or notifications related to my claim, and pursue all legal and equitable claims in TGH's or Healthcare Provider's (as applicable) name or in my name, including claims for attorneys' fees and costs, that I may have against my Health Plan arising

from payment denials or reductions, improper claims administration and processing, or other misconduct. The authorizations in this section are irrevocable.

III. Release of Medical Information: I authorize TGH to release any and all information, including copies of medical records in electronic or paper form, to any person or entity for the purposes of treatment, health care operations, and payment, including releasing information to agents or employees of my insurance company or other payers. I specifically authorize the release of information pertaining to any psychiatric care and treatment (but not "psychotherapy notes" as that term is defined by law), mental health care and treatment, HIV serology results, alcohol treatment, and substance abuse care and treatment pertaining to me. If I have or receive an implantable device, unless I strike through this sentence, I consent to the release of my Social Security Number to the device manufacturer. I authorize and allow for any exchange of personal health information as required by law and the disclosure of all elements of data to be exchanged. I consent to the transfer of electronic data between TGH and its business associates and other health care facilities for the continuity of care and outpatient services. I understand that my physician will be sent an automatic notification of my admission. For a more detailed description of uses and disclosures for treatment, payment or normal healthcare operations, please review the Notice of Privacy Practices provided to you.

IV. Valuables/Belongings Release: By signing in the space as Patient or Guarantor (party responsible for payment of account), I acknowledge I have the opportunity to use a safe at TGH. Any valuables, belongings or money that remain with me are not TGH's responsibility if they are lost or stolen. This includes clothing, jewelry, eyeglasses, dentures, hearing aids and other personal belongings, including cell phones, and other electronics.

V. Payment Agreement: I agree all charges are due at the time of discharge for inpatient services and at the time of service for outpatient services. I am responsible for the full charges of the services I receive, and I am personally responsible for any unpaid charges if third-party source(s) do not pay in full or otherwise reject payment of my claim. Unless otherwise agreed in writing, I agree any partial payments received by TGH or any Healthcare Provider do not constitute "accord and satisfaction" or otherwise effect a settlement or resolve an existing dispute as to amounts due and owing by me to TGH or any Healthcare Provider (as applicable). I further acknowledge TGH and Healthcare Provider do not accept reference-based pricing from myHealth Plan. I agree that if I receive payment directly from any other third- party source for the charges associated with my treatment, it is my responsibility to immediately pay such payments to TGH or any Healthcare Provider (as applicable).

I understand that any bill I receive from TGH is separate from the Healthcare Providers' bills I may receive, which may include invoices from InPhyNet Contracting Services, Inc., Radiology Associates of Florida, USF, University Medical Services Association, Ruffolo Hooper and Associates or other providers, none of which are included in the TGH bill. TGH makes no guarantee that any Healthcare Providers are contracted with my health insurance provider.

In accordance with Florida Statute 395.301, I acknowledge that I have been informed of my right to an itemized bill. Please call (813-844-7291) after your discharge to request a copy of your bill. I understand that I am responsible to pay for any private room differential in the event that my insurer does not cover this expense.

If I fail to pay any obligation to TGH which is determined to be my personal responsibility according to law, I will be responsible for all costs of collection, which may include attorneys' fees and court costs, and include pre-judgment and post-judgment interest at the rate set forth in the Florida Statutes.

Overpayments: Before we refund a credit balance or overpayment on your account, we will apply that amount to any outstanding balances owed to us by you. We will refund you for any remaining credit balance.

VI. Financial Information. I acknowledge that during the course of my admission, stay, and after discharge, I may be asked to provide financial information for the purposes of determining eligibility for uncompensated or discounted care, applying for government programs, instituting payment arrangements, or for other related purposes. I hereby certify that such information provided by me will be provided in good faith and will be accurate to the best of my knowledge. I hereby authorize TGH to obtain credit reports concerning me from one or more credit bureaus. I understand TGH may obtain credit reports concerning me without my written authorization under some circumstances, as permitted by law. I hereby authorize TGH to provide information about me (whether received from me or from a credit bureau) to third parties for business-related purposes, including billing, collection, instituting payment arrangements, and determining eligibility for uncompensated care, discounted care, and/or government programs.

VII. Communications. I authorize TGH and/or its business associates to contact me via telephone, cellular phone, and/or electronic mail, which may include pre-recorded messages, auto-dialers, artificial voice messages, text messages, and/or other forms of automated/electronic communication at any telephone number I provide. I understand that electronic mail communications can be intercepted in transmission or misdirected and my use of electronic mail communication to TGH indicates I acknowledge and accept the possible risks associated with such communication. To the extent I have provided TGH a cellular phone number or e-mail address, I am consenting for TGH and/or its business associates to contact me via such cellular phone or e-mail address, with communications that may include information about my account and efforts to collect any outstanding invoices. This authorization will remain in effect until five (5) business days after I rescind this authorization, which must be done in a writing provided to TGH at Post Office Box 1289, Tampa, FL 33601-1289, Attention: Patient Financial Services.

I have received TGH's Notice of Privacy Practices.____________________
Please initial here.

I have received TGH's Rights and Responsibilities.____________________
Please initial here.

Should you need additional information on any matter contained concerning your rights or responsibilities as a patient, please contact the TGH's Office of Patient Relations at (813) 844-7249.

____________________________________ ____________
Signature Date

____
Print Name

____________________________________ ____________
Witness Date

As: ☐ Patient ☐ Patient's Spouse ☐ Parent or Guardian
☐ Other/Specify Relationship:____________________________

TGH Behavioral Health Hub Certification and Authorization for Diagnostic Procedures and Medical Treatment

Patient Label

Demographics:

Name of the person completing this form:______________________________

Relationship to the child:______________________________

Phone:______________________________ Email:______________________________

Child's full legal name:______________________________ Child prefers being called:______________________________

Child's date of birth:____________________ Age:____________________ Race:____________________

Ethnicity:____________________ Gender:____________________ Religion:____________________

Child's Primary Care Provider:______________________________

Household information: Please list who lives in the same household as the child.

Name	Sex	Age	Relationship to Child

Medical and Dental History

Date of last physical exam: _______ / _______ / _______ Are vaccinations up to date? ☐ Yes ☐ No

Allergies: ☐ Yes ☐ No If yes, list all known allergies (mediations, supplements, foods, environmental):

____

____

Medical conditions: ☐ Yes ☐ No ☐ Unknown If yes, check all that apply:

☐ Asthma ☐ Diabetes ☐ Obesity ☐ Cardiovascular disease ☐ Head injury ☐ High blood pressure

☐ Low blood pressure ☐ Hyperlipidemia ☐ Dizziness or fainting ☐ Convulsions/seizures/epilepsy

☐ Hearing problems ☐ Loss of consciousness ☐ Respiratory illness ☐ Urogenital problems ☐ Vision problems

☐ Other:______________________________

Previous history of surgery, please describe and give dates:______________________________

____

____

If your child has had any serious injuries, please describe and give dates:____________________

____

____

Biological females only, if your child has started menstruation, at what age:____________________

Are periods regular? ☐ Yes ☐ No

Current Medications: (Attach additional pages if needed.)

Name of Medication	Dose of medication	Duration of Treatment	Who is the prescriber?

Please list any medications the child has taken in the past:____________________

____

____

Routine dental visits? ☐ Yes ☐ No Date of last dental visit: _______ / _______ / _______

Psychiatric History

In addition to listing previous therapists and psychiatric care, please indicate if the patient has ever received any of the following diagnoses (check all that apply):

☐ ADHD ☐ Depression ☐ Anxiety ☐ Autism Spectrum Disorder ☐ Schizophrenia ☐ Bipolar Disorder

☐ Disruptive Mood Dysregulation Disorder (DMDD) ☐ Post-Traumatic Stress Disorder (PTSD)

☐ Obsessive Compulsive Disorder (OCD) ☐ Oppositional Defiant Disorder (ODD) ☐ Other:____________

What are the main concerns that you have about the child's behavior or emotions?____________________

____

____

How long have you had these concerns?____________________

____

Does the child engage in any self-harm behavior (like cutting)? ☐ Yes ☐ No If yes please describe:

____

____

Has the child ever been violent? ☐ Yes ☐ No If yes please describe:

____

Has the child ever been aggressive? ☐ Yes ☐ No If yes please describe:

____

If you mentioned concerns related to aggression or violence.
Have you or the patient's school observed any concerning patterns or behaviors?______________________

Does the child use alcohol? ☐ Yes ☐ No If yes please describe:

____

Does the child use tobacco or vape? ☐ Yes ☐ No If yes please describe:

____

Does the child use illegal drugs? ☐ Yes ☐ No If yes please describe:

____

Has the child ever seen a psychiatrist or therapist/counselor before ☐ Yes ☐ No

Name of provider	**Dates seen**	**Reason**

Has the child ever been admitted to a psychiatric hospital? ☐ Yes ☐ No

Name of psychiatric hospital	**Dates admitted**	**Reason**

Family History

Please identify any known psychiatric illnesses in blood relatives of the child.

Diagnosis	**Child's Mother**	**Child's Father**	**Child's Siblings**	**Mother's Familial side**	**Father's Familial side**
Anxiety					
Attention Deficit/ Hyperactivity Disorder					
Autism					
Bipolar Disorder					
Depression					
Eating Disorder					
Intellectual Disability of learning problems					
Psychosis					
Schizophrenia					
Substance Misuse (alcohol, drugs)					
Suicide					

Social History

Name of current school:	
Current grade:	List grades repeated or NA:
IEP or 504 plan ☐ Yes ☐ No	ESE or special needs classes ☐ Yes ☐ No
Describe school issues (behavioral and academic):	

Trauma History

Beyond what has already been shared, has the patient experienced or witnessed any events they perceived as traumatic?

____

____

Has the patient ever been a victim of bullying? ☐ Yes ☐ No If yes please describe:______________

Has the patient ever acted as a bully or aggressor? ☐ Yes ☐ No If yes please describe:______________

Developmental History

During your pregnancy with this patient:

Did you take any medications or experience any complications? ☐ Yes ☐ No If yes please describe:

____

Was the patient born ☐ Full-term or ☐ Early? If early, please share anything you feel would be helpful for us to know:

____

Were there any birth complications? ☐ Yes ☐ No If yes, please describe:

____

Did you smoke cigarettes or use any tobacco products during pregnancy? ☐ Yes ☐ No If yes please describe:

____

Were there any important delays or concerns during your patient's development,
such as walking, talking, or potty training? If so, please explain:______________

____

Testing History

Any history of IQ or achievement testing? .... ☐ Yes ☐ No

Ever been tested for hearing abnormalities? .... ☐ Yes ☐ No

Ever been tested for speech/ language abnormalities? .... ☐ Yes ☐ No

Has the child ever received occupational or physical therapy? .... ☐ Yes ☐ No

Adoption ☐ Yes ☐ No Are they aware? ☐ Yes ☐ No Please describe:

___

Foster care/removal of child from home? ☐ Yes ☐ No If yes please describe:

___

Other separation from parent/family? ☐ Yes ☐ No If yes please describe:

___

Illness in family? ☐ Yes ☐ No If yes please describe:

___

Death of a parent, loved one, close friend? ☐ Yes ☐ No If yes please describe:

___

Family financial problems? ☐ Yes ☐ No If yes please describe:

___

Loss of home? ☐ Yes ☐ No If yes please describe:

___

Parent separation/divorce? ☐ Yes ☐ No If yes please describe:

___

Unwanted pregnancy? ☐ Yes ☐ No If yes please describe:

___

Victim of crime or violence? ☐ Yes ☐ No If yes please describe:

___

Other: ___

Please elaborate on any of the above, how they have affected the child, and any symptoms as a result.

___

___

___

___

___