For Lee Health System d/b/a Lee Health ("Lee Health") facilities, including but not limited to: Lee Physician Group, Lee Convenient Care, Lee Memorial Hospital, HealthPark Medical Center, Gulf Coast Medical Center, and Cape Memorial Hospital, Inc. d/b/a Cape Coral Hospital.

NOTICE OF LIMITED LIABILITY

I, ON BEHALF OF MYSELF, MY CHILD, AND/OR MY WARD, ACKNOWLEDGE I HAVE BEEN INFORMED THAT: Medical care and treatment that I receive at a Lee Health facility may be provided by Lee Health-employed physicians, surgeons, nurse-midwives, physician assistants, nurse practitioners, and other individuals (all herein "Providers") who are employees or agents of Lee Health. I understand that those Providers that are Lee Health employees and agents are under Lee Health's exclusive supervision and control and that the liability for the acts or omissions of these Lee Health Providers is limited to $200,000 per claim or judgment by any one person and to $300,000 for all claims or judgments arising out of the same incident or occurrence (see Section 768.28, Florida Statutes).

I further acknowledge that I may receive medical care and treatment from other independent health care contractors, including, but not limited to, my private practicing physician, radiologists, anesthesiologists, emergency care providers, pathologists, and perfusionists, who are neither employees nor agents of Lee Health. I recognize and agree that Lee Health is NOT responsible for the acts or omissions of these independent health care contractors.

Patient / Legal Representative: _____ Date:_____ Witness_____

1. **ASSIGNMENT OF BENEFITS AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.** I hereby assign to Lee Health payment from all third party payors* with whom I have coverage or from whom benefits are or may become payable to me, for the charges of hospital and health care services I receive for, related to, or connected with my admission or treatment (past, present, or future). I agree to be personally responsible for payment of any hospital or health care services that are not covered by my third party payors*, including, but not limited to, non-covered or out-of-network services, deductibles, coinsurance, and/or co-payments. I also assign payment of any available insurance benefits to the physician(s) who provide treatment to me at Lee Health. I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to Lee Health any and all Plan documents, summary benefit description, insurance policy, and/or settlement information. I intend by this assignment and designation of authorized representative to convey to Lee Health all of my rights to claim the medical benefits related to the services provided by Lee Health, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). Lee Health is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or choses in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. Lee Health as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing.

2. **RELEASE OF INFORMATION.** I acknowledge that Lee Health is authorized under Florida state and U.S. federal law to release copies of my billing and medical records, to ensure payment for hospital and health care services I receive for, related to, or connected with my admission or treatment (past, present, or future), to secure additional treatment if needed, and to otherwise facilitate health care operations related thereto, to the following persons or entities: any health care facility or affiliated provider; my referring or treating providers; ambulance and similar transportation providers; the Guarantor on my accounts and any third party payors* or their agents; any Florida state or federal regulatory entities and accrediting organizations; the Social Security Administration, the Florida Department of Children and Family Services, and other similar entities. This specifically includes health information concerning psychological conditions, psychiatric conditions, and/or infectious diseases including, but not limited to, blood-borne diseases such as Hepatitis, Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). If my admission or treatment is due to a motor vehicle accident, I authorize Lee Health to obtain a copy of my "crash report" required by Florida Statutes to facilitate third party payment and/or obtain my automobile insurance information from The Florida Department of Motor Vehicles.

3. **LEE HEALTH FINANCIAL PRACTICES.** I understand and agree that:

   (a) Lee Health's charges for hospital services are set out in the hospital's price list (the "Charge Master"). The relevant portions of which I may examine during regular business hours at the Financial Services office located at 224 Santa Barbara Blvd., Cape Coral, FL 33991. Lee Health reserves the right to review and change the prices set out in the Charge Master.

   (b) Lee Health's account of my hospital charges is an "open account" that will include all of my hospital charges and all payments, whenever such charges or payments are made, as part of a single transaction giving rise to a single liability and Lee Health may prepare bills for amounts up to and including the account's total amount due on a regular basis.

   (c) The amount that I am obligated to pay may differ from the amounts other patients are obligated to pay based upon each patient's ability to pay and third party payor coverage.

   (d) I may request and will be provided with information about Lee Health's financial assistance programs. Collection of some or all of my account balance(s) may be suspended if I qualify for a financial assistance program by meeting the relevant income tests and otherwise lack the ability to pay all the hospital's charges. However, even if I qualify for financial assistance, I agree that my account balance(s) remain payable from health or accident insurance, worker's compensation or other third party sources and third party recoveries such as liability settlements and judgments. Liability settlements and judgments remain subject to a lien of Lee Health pursuant to this agreement and Florida law.

   (e) As a courtesy, Lee Health may bill third parties, including my insurance company, but it is not obligated to do so. Regardless, I agree, except where prohibited by law, to pay those charges reflected on Lee Health's uniform billing instruments (UB-04 or CMS-1500 forms) for services rendered to me at Lee Health.

4. **FINANCIAL RESPONSIBILITY.** I hereby agree to the following:

   (a) I am responsible for paying the charges of all hospital and health care services the Patient receives for, related to, or connected with the Patient's admission or treatment (past, present, or future), and that charges are due and payable at the time of discharge or discontinuation of treatment. The charges I agree to pay are those listed in Lee Health's Charge Master in effect at the time the services were rendered and as reflected on the Hospital's uniform billing instrument (UB-04 form).

   (b) Unless otherwise precluded by law or contract, if as a courtesy Lee Health bills third party payors*, Lee Health may demand payment in full of any balance due, at any time.

(c) I understand that I will be **billed separately** by Lee Health for services rendered by it (including Lee Health-employed Providers) and by any independent contractor who provides services to me (for example, my private practicing physician, anesthesiology, radiology, pathology or laboratory services).

(d) Any overdue accounts may be referred to a collection agency or attorney, in which case I agree to pay attorney's fees, court costs, and/or collection agency fees associated with the collection process.

(e) I agree to Lee Health inquiring into my credit history in conformity with legitimate business needs and applicable laws, rules and regulations and further agrees that the hospital may, with or without notice, assign, transfer and convey to any agency or attorney its right, title and interest in and to any balance due after the patient's discharge.

(f) I authorize Lee Health to apply non-insurance payments received that exceed the amount necessary to pay Lee Health's charges for this hospitalization to the payment of any unpaid Lee Health bills of myself or of my immediate family.

(g) I authorize Lee Health, its service providers (including service providers contacting me about financial assistance or regarding payment and/or for collection services) and their successors, assigns, affiliates, independent contractors or agents to contact me in person, using pre-recorded or artificial voice messages and/or an automatic telephone dialing system at any telephone number associated with my account(s), including my wireless telephone number, whether provided in the past, present or future unless such authorization is revoked by me in writing. In the event any of my telephone numbers change while payment is still due and owing on my account, I agree to immediately inform Lee Health in writing that the telephone number provided is no longer mine and agree to indemnify Lee Health, its service providers, successors, assigns, affiliates, independent contractors or agents from any damages, including attorneys' fees and costs, relating to calls made to any previously provided telephone number.

5. **LIEN ON THIRD PARTY LIABILITY PROCEEDS.** If my admission or treatment is due to an accident or injury, Lee Health shall have a lien upon the proceeds of any cause of action, suit, claim, counterclaim, or demand accruing to me or my legal representative as a result of such accident or injury, in order to recover payment for all charges of hospital and health care services I receive for, related to, or connected with such accident or injury effective as of the date treatment was first provided. I understand and acknowledge that Lee Health also expressly reserves the right to secure payment of some or all of its charges by recording its hospital lien and/or providing notice of its lien to any and all third parties deemed appropriate by Lee Health in its sole and absolute discretion. In such event, Lee Health may, in its sole and absolute discretion, seek recovery for payment of its charges from the proceeds of any payment made by third parties on account of the accident giving rise to the treatment provided by Lee Health. I understand and acknowledge that the amount demanded by Lee Health from third party source(s) may and likely will exceed the amount that would otherwise be payable from third party payors, including, but not limited to, health insurance, HMO, or health plan coverage. I agree to provide Lee Health upon request with the name of any person that may have caused my injuries, the name of the person's insurance company, the name of my lawyer and any other information that may help Lee Health exercise its rights and/or providing notice of its lien to any and all third parties deemed appropriate by Lee Health in its sole and absolute direction.

6. **VALUABLES RELEASE.** I acknowledge that I have been given the opportunity to deposit valuables and money with Lee Health for safekeeping. I understand that Lee Health assumes no responsibility for personal property (including, but not limited to, valuables, money, cell phones, beepers, shoes, or clothing) retained by me, and I hereby release Lee Health, its directors, officers and employees, from any and all liability for loss of such personal property and I will personally assume all loss, cost, or expense incurred as a result of any such loss.

7. **STUDENTS.** Lee Health supports the training and education of health care professionals and technicians and provides opportunities for practical learning experiences. I acknowledge that I may be cared for by students or other health care personnel in supervised training programs. I acknowledge that I can advise my nurse or physician if I choose not to have such individuals participate in my care.

8. **GENERIC MEDICATIONS.** Medications used at Lee Health are selected by the Pharmacy and Therapeutics Committee of the Lee Health Medical Staff. Whenever possible, generic medications are administered, rather than "brand names" products. For my convenience and for ease of understanding what medications I am receiving, they may be referred to by their brand names even though the generic equivalent is what is actually used.

9. **RECYCLING.** In strict accordance with U.S. Food and Drug Administration standards, Lee Health sends some disposable medical and surgical supplies to be processed and sterilized for re-use. This is a safe, environmentally sound, cost-saving measure.

**Third party payors include, but are not limited to, coverage available from: Medicare, Medicaid, Tri-care, or governmental programs; health, accident, automobile, or other insurance; workers' compensation; HMOs; self-insured employers; and any sponsors who may contribute payment for services.*

I, the undersigned, as the patient, or the guardian, spouse, guarantor or agent of the patient, hereby certify that: (a) I have read, and fully and completely understand these Conditions of Services; (b) I have signed this Conditions of Services knowingly, freely, voluntarily and agree to be bound by its terms; (c) the Conditions of Services set forth above shall govern my rights and obligations as patient, guardian, spouse, guarantor or agent of the patient as to any treatment or services that are provided by Lee Health to the patient during any current or future admission; (d) this Conditions of Services constitutes the entire agreement of the parties and supersedes all prior understandings or agreements, oral or written, among the parties on the subjects addressed; and (e) I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained by any treatment or services.

PATIENT / PARENT / GUARDIAN SIGNATURE DATE TIME

PATIENT'S SPOUSE / HEALTHCARE POWER OF ATTORNEY / OTHER LEGAL REPRESENTATIVE DATE TIME

☐ **Patient is Unable to Sign and does not have a Representative** ☐ **Patient Refused to Sign**