MRN:_____ Patient Name:_____ Visit Date:_____ Clinic Name:_____

NOTICE OF LIMITED LIABILITY
The care, treatment and services ("Care") provided by Shands Teaching Hospital and Clinics, Inc., Shands Jacksonville Medical Center, Inc. ("Shands") and the University of Florida ("University") are subject to the provisions of s. 768.28, Florida Statutes, which limits recovery for a claim or a judgment by any one person to $200,000, or any claim or judgment, or portion thereof, which, when totaled with all other claims or judgments arising out of the same incident or occurrence, to $300,000.

CONSENT AND AUTHORIZATION

I. **Authorization for Medical Care:** I consent to any Care that may be considered necessary and/or advisable in the judgment of my Healthcare Provider. I understand that my Healthcare Provider is an employee or agent of the University of Florida Board of Trustees. I also understand that my Healthcare Provider will be providing Care to me in a healthcare teaching and research institution and that my Care will be observed, and in some instances aided, by students under appropriate supervision. I authorize the University or any of its affiliates to retain, preserve and use for scientific or educational purposes, or dispose of as they might deem fit, any specimen or tissues taken from my body. I consent to the University videotaping and photographing me in the course of and related to my Care and to their use of such videos, photographs, and my medical data for educational purposes within the University. If applicable, this authorization is also given on behalf of my unborn child. I understand that my physician may access my medical information from a variety of sources, including information about my medication use that comes from electronic prescribing software and databases. **Telemedicine**. I understand and agree that my Healthcare Provider may utilize telemedicine (the electronic communication of medical information) including, but not limited to, videoconferencing, electronic transmission of imaging, and remote monitoring of vital signs as part of my Care. Except in emergency circumstances, my Healthcare Provider will explain the risks and benefits of telemedicine prior to the telemedicine encounter. I understand that I have the right to seek Care elsewhere in lieu of a telemedicine encounter.

II. **Risk Management and Dispute Resolution:** I agree that my patient information (including, but not limited to, my medical records, billing information, and information I disclose to a health care provider in the course of my Care) may at any time be used by and disclosed to employees, officers, agents, and legal representatives of the University and/or Shands for purposes of risk management, and formal and informal dispute resolution processes (including, but not limited to, litigation and mediation) involving one or both of these entities.

III. **Release of Medical Information:** I authorize the University to release information from my medical records (including information relating to psychiatric and/or psychological care, alcohol and/or substance abuse, and HIV tests) and any other information that may be required to secure payment for charges incurred by me or on my behalf to: (1) any University facility or affiliated provider; (2) my referring physician; (3) the guarantor on my accounts; (4) any Third Party Payor[1] that contributes payment for my Care. In addition, I authorize the release of any information to county, state or federal public health agencies, as required by law.

IV. **Assignment of Benefits and Responsibility for Payment:** I assign to the University payment from any Third Party Payor with whom I have coverage or from whom benefits are or may become payable to me, for Care I receive (past, present, or future). I agree to be personally responsible for payment of any Care that is not covered by a Third Party Payor, including, but not limited to, non-covered or out-of-network services, deductibles, co-insurance, and/or co-payments.

V. **Guarantor Agreement:** By signing in the space below as Patient/Guardian or Guarantor or as Patient's/Guardian's Spouse or Guarantor's Spouse, I agree that all charges connected with Care not covered by any Third Party Payor are due and payable by me at the time the Care is rendered or at the discontinuation of Care. If the insurance information I have provided is not active at the time of Care, I will be responsible for any balance due at the time the Care is rendered. The charges I agree to pay are those listed in the University's current fee schedule (which is available for inspection upon request) as modified by any applicable contract the University may have with a Third Party Payor. I understand that billing statements will be sent to the patient to whom the Care has been rendered, but as guarantor, I am responsible for payment. I acknowledge that, unless the University and my Third Party Payor have agreed that I will not be billed, if the University has agreed to bill my Third Party Payor it has agreed to do so as a courtesy and that the University has the right to demand payment in full from me at any time prior to full payment from any Third Party Payor. If an overdue account is referred to collections, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process. I consent to the University or any third party contacting me by telephone, including my cellular phone, for purpose of collecting any amounts owed by me. I specifically waive any exemption of wages from garnishment, which might be available by law, and agree that my wages can be garnished in the event a judgment is entered against me for collection of charges I have agreed to pay.

VI. **Agreement to Pay for Professional Component of Pathology Services**: When a specimen of my blood, urine, stool, or similar material is tested, the testing will be performed under the supervision of the pathologist who directs the laboratory. The pathologist may not perform the test or personally review its results. However, the pathologist is responsible for supervising the laboratory. I will receive a bill from the pathologist for these supervisory services for each test even if the pathologist did not personally perform the test or review its results. By signing this document, I agree to be responsible for the pathologist's bill to the extent that payment is not provided by my Third Party Payor.

VII. **Agreement to Mediate:** In accepting Care at a University facility, I agree that before I file any lawsuit against the University or any of its facilities, employees or agents, and/or the University of Florida Board of Trustees, arising out of the Care provided to me by my Healthcare Providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party person who has been certified to be a mediator tries to help settle claims. The University will pay the cost of the mediator. I further agree that any mediation must take place in the State and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

Patient/Guardian/Guarantor_____ Date: _____

Printed Name/Relationship to patient: _____□ Self □ Guardian □Guarantor □ Insured

Witness_____Date_____

COPIES OF THIS STATEMENT SHALL BE VALID AS THE ORIGINAL/ORIGINAL SIGNATURES ON FILE WITH THE UNIVERSITY OF FLORIDA

[1] "Third Party Payors" include, but are not limited to, Medicare, Medicaid, Tri-care, governmental programs, health, accident, automobile, or other insurance, worker's compensation, HMO (commercial, Medicaid, Medicare), self-insured employers and any other sponsors who may contribute payment for Care.