SOUTH COUNTY
HEALTH

GENERAL CONSENT TO TREAT

(Valid for all hospital and outpatient services except invasive procedures, surgery, or anesthesia, which require separate consent)

I, the undersigned patient or legal representative, give my consent as follows:

1. **CONSENT TO TREATMENT**
   I authorize South County Health, its physicians, advanced practice providers, nurses, allied health professionals, and staff to provide routine and emergency care necessary for diagnosis and treatment. This includes, but is not limited to, physical examinations, diagnostic tests, laboratory tests, imaging, medications, vaccinations, and other nonsurgical procedures.
   I further understand that tissue, fluid, and bone may be removed during medical care or surgery, and I consent to the photographing, and use of such material in research.
   I understand that I may refuse or withdraw consent for any specific test or treatment at any time by notifying my care team.
2. **DURATION OF CONSENT**
   This consent remains in effect for the entire course of my care during this visit at South County Health—including outpatient visits, emergency care, and inpatient admission—until I revoke it in writing.
3. **TEACHING & TRAINING ENVIRONMENT**
   I understand that South County Health utilizes medical, nursing, and other health-profession students or trainees, under appropriate supervision, who may participate in my care. I consent to their involvement.
4. **VIDEO MONITORING & SECURITY**
   I understand that security and other cameras may be used in certain public or clinical areas for safety. Cameras are not used in private spaces such as restrooms or changing areas.
5. **TELEMEDICINE CONSENT**
   I consent to discussing my confidential and protected health information and receiving treatment through interactive audio, video, or data communications (collectively referred to as "telemedicine") as if my providers or other SCH personnel were speaking with me in person at South County Hospital or other SCH site. I understand that I need to participate in telemedicine from a private area to protect my confidentiality. Risks associated with telemedicine include disruptions, technical difficulties and failures, or unauthorized interception of information by unauthorized persons during transmission or storage.
6. **RIGHT TO ADVANCE DIRECTIVES**
   If I am admitted as an inpatient or observation patient, I have the right to make medical decisions and to have advance directives, such as a living will or durable power of attorney for health care. It is my responsibility to provide my care team with a copy of my advanced directive to ensure my wishes are known and respected.
7. **COMMUNICATIONS**
   I authorize SCH and its providers, business associates, and agents to contact me regarding my care, appointments, or billing by phone, voicemail, text message, email, or other secure means. I understand these communications may include the use of automated systems or prerecorded messages, and that standard message or data rates may apply.
8. **FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS**
   I understand that I am financially responsible for all charges for services provided, including amounts not covered or paid by insurance or other third-party payers, consistent with Rhode Island law. I authorize payment of insurance benefits, including Medicare benefits, directly to the hospital for services rendered.

9. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received (or been offered) a copy of South County Health's *Joint Notice of Privacy Practices,* which describes how my protected health information may be used or disclosed for treatment, payment, and healthcare operations and how I can access this information.

10. USE OF TECHNOLOGY

I understand that South County Health may use current and future technologies—including electronic health systems, digital imaging, artificial intelligence–assisted diagnostics, or robotic technologies—under the supervision of licensed providers to support my diagnosis, treatment, and hospital operations.

11. RECORDING AND AI TRANSCRIPTION

I understand that during my visit, my healthcare provider may use a secure voice recognition and transcription system to document information discussed during my appointment.

I have been informed that:

- The system may record or transcribe portions of the conversation between me and my provider for the purpose of clinical documentation and care coordination. A third party vendor ("AI Vendor") provides the system under the agreement to South County Health.
- The technology used is compliant with the Health Insurance Portability and Accountability Act (HIPAA), and all information will be handled as Protected Health Information (PHI).
- The transcription is stored securely and accessible only to authorized healthcare personnel and the AI Vendor.
- No part of the recording or transcription will be shared outside my care team and the AI Vendor without my authorization.

I consent to the use of this technology for clinical documentation purposes.

I understand that I may withdraw my consent at any time, and doing so will not affect my right to receive care.

12. MEDICATION HISTORY

To enhance safe treatment and avoid drug interactions, I authorize South County Health to obtain my prescription medication history from pharmacies, healthcare providers, and my health plan.

13. SAFEKEEPING OF VALUABLES

I understand that it is best to leave valuables at home. If necessary, I may place valuables in the hospital safe. Items not claimed within 90 days after discharge may be disposed of or donated at the hospital's discretion. The hospital is not responsible for loss or damage to any personal property not placed in safekeeping.

Patient Name: _____ Date of Birth: _____

Patient / Legal Representative Signature: _____ Date: _____

Print Name & Relationship (if not patient): _____

Witness Name & Title (if patient unable to sign): _____

Signature: _____ Date: _____

INTERPRETER STATEMENT (IF APPLICABLE)

I accurately explained the content of this form to the patient or legal representative in their preferred language and answered all questions.

Interpreter Name & ID: _____

Language: _____ Signature: _____ Date: _____