HEALTH CARE CONSENT

1. TO TREAT: I, for myself (or the patient named below) and if applicable, any infant I deliver, hereby consent to such diagnostic procedures and medical treatment as necessary and appropriate for my condition or illness, which may include HIV testing, unless I specifically opt-out of the HIV testing by informing my treating provider that I decline such testing. The diagnostic procedures and medical treatment to be provided shall be determined by my physician(s) or other appropriate practitioners, as necessary or advisable at the time treatment is performed, and shall be provided at the hospital, by staff physicians on the hospital medical staff, nurses and other health care providers. I understand that health care providers in training, may, under the supervision of appropriate personnel, participate in my treatment.
2. COORDINATION OF CARE: I understand that Advocate Health Care is a clinically integrated health system that is comprised of multiple hospitals, medical groups, and other health care provider entities that all work together to provide high quality patient care and to ensure efficient coordination of patient care. I understand that Advocate will store my patient health information in an Electronic Medical Record format and that my medical record, including but not limited to my diagnosis, treatment plan, prescription information, appointment schedule and lab and other diagnostic results (including HIV-related information, genetic information, and behavioral health records), will be viewable by individuals who are members of my interdisciplinary care team across the entire Advocate Health Care system. The interdisciplinary care team is comprised of employees, contractors, agents, and medical staff members of Advocate Health Care, its affiliates and Advocate Medical Group, among others, who work together for admission, treatment, planning, coordinating care, discharge or governmentally mandated public health reporting purposes.
3. PHOTOGRAPHY: I understand that my provider may need to take photographs, video and/or audio recordings to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or help plan details of surgery. I understand that my provider or the hospital will retain the ownership rights to these photographs, videos and/or audio recordings. I also understand that these images may be used for advancing education provided the patient identifiers are not revealed.
4. HOME HEALTH CHOICE: I understand that I have the freedom to choose and the right to select my home care provider for care I might need. I am aware that, in order to improve continuity and quality of care, the hospital will generally use Advocate at Home unless I select a different provider or as directed by my insurance carrier. A list of home care providers is provided to me at Admission/Registration. Upon request, a discharge planner can provide another copy of the list. If I prefer a different provider, my preferences will be honored.
5. EXTERNAL PRESCRIPTIONS: I authorize access to my external prescription history for the purpose of facilitating my care. The information will only be available if my prescriptions were filled through a participating pharmacy. Therefore, it remains my responsibility to provide an accurate medication history.
6. LANGUAGE CHOICE: My preferred language for receiving health information is (English). I have been provided information regarding translation and interpreter services. I understand these services are available at no cost and that I may request these services at any time during my admission.
7. LIMITED AUTHORIZATION TO SHARE BILLING AND INSURANCE INFORMATION: By initialing in the space I direct the hospital to release information regarding the status of insurance claims and outstanding balance to the person designated below, who is involved in the payment for my care. I understand this authorization is limited to billing status and insurance status for the treatment event covered by this Health Care Consent. For any future treatment events, I must re-designate this individual to have information shared with him or her. This designation may be revoked at any time by written notice to the Health Information Management/Medical Records Department (with no effect on prior disclosures).

   Initial: _____ **Designee:** _____ **Relationship:** _____
8. RELEASE OF MEDICAL INFORMATION FOR PAYMENT: I hereby consent to the release of any and all pertinent information contained in my medical records, including HIV-related information, genetic information, and behavioral health records, to third party payors responsible for payment of patient charges including, but not limited to, insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above.
9. ASSIGNMENT OF BENEFITS: In consideration of services rendered at the hospital, I hereby assign and authorize direct payment to the hospital and the treating physicians, any insurance, health plan or third party payer benefits otherwise payable to me or on my behalf for this hospitalization, emergency room care or outpatient services.
10. MEDICARE PAYMENT AND ASSIGNMENT OF BENEFITS (if applicable): I request that payment of authorized Medicare benefits be made on my behalf for hospital and physician services furnished to me at the hospital and I assign such benefits to the hospital and physicians providing same. I certify that the information given by me in applying for such benefits is correct and that I have completed a Medicare questionnaire. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed for payments of such benefits. I authorize the Social Security Administration to release information about my entitlement to benefits to hospital and physicians providing services to me.

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11. PERSONAL BELONGINGS: I assume full responsibility for all items of personal property, including but not limited to, eyeglasses, hearing aids, dentures, jewelry, currency and all other valuables. I understand that valuables may be kept in the hospital safe upon my request and hereby release the hospital of responsibility and liability for those valuables and items of personal property which are not deposited.

12. FINANCIAL ASSISTANCE: In consideration of services to be rendered at the hospital, as the patient or legal representative of the patient, the patient agrees to pay the hospital for all services, facilities and supplies provided to the patient at the established rates, including any deductible, co-payment or charges not covered by third party payors. **I understand that the hospital bill does not include physician services and the patient will receive separate physician bills from physicians for their services.** Some physicians on the medical staff may not participate in the same health plans as the hospital and I understand the patient may have to pay a higher proportion of the physician bill as an "out of network" provider. The patient accepts responsibility for any costs, including attorneys' fees, incurred in the collection of these charges. I understand that if I do not consent to release of records or later revoke such consent, the patient is fully responsible for payment of all charges for diagnosis and treatment received. I certify that the information given by me for purposes of payment for this hospital treatment is, to the best of my knowledge, complete and accurate. I understand that if the patient is having difficulty in meeting his/her payment responsibilities to the hospital, information on financial assistance including reasonable payment plans and financial assistance is available upon request as part of the hospital's financial counseling services. I understand that questions about coverage or benefit levels should be directed to the patient's health care plan and the patient's certificate of coverage. In addition, I have been offered a copy of the financial assistance plain language summary, which describes the financial assistance policy and application.

13. INDEPENDENT PHYSICIAN/PROVIDER SERVICES: I ACKNOWLEDGE AND FULLY UNDERSTAND THAT **ONLY THOSE PHYSICIANS/ PROVIDERS WHO ARE CLEARLY IDENTIFIED AS ADVOCATE EMPLOYEES ARE EMPLOYEES OR AGENTS OF ADVOCATE HEALTH CARE. NON-EMPLOYED PHYSICIANS/PROVIDERS ARE INDEPENDENT PROVIDERS WHO ARE PERMITTED TO USE THE HOSPITAL FACILITIES TO RENDER MEDICAL CARE AND TREATMENT.** Non-employed physicians include, but are not limited to, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology and other specialties. These independent physicians/providers exercise their own medical judgment in treating me or otherwise providing professional services to me. I understand that I should ask my physician any questions I may have about his or her employment status. My decision to seek medical care at the hospital is **NOT BASED UPON ANY UNDERSTANDING, REPRESENTATION, ADVERTISEMENT, MEDIA CAMPAIGN, INFERENCE, PRESUMPTION, OR RELIANCE THAT THE PHYSICIANS PROVIDING CARE AND TREATMENT TO ME ARE EMPLOYEES OR AGENTS OF THE HOSPITAL OR ADVOCATE HEALTH CARE.**

By my signature below, I confirm that I acknowledge and understand that the hospital uses independent contractors or practitioners to provide various services as described above. I further acknowledge that I have read this consent form, including the specific language related to independent physician services, and have had the opportunity to ask questions, and that any questions have been satisfactorily answered.

I have read and understand the above terms of treatment and confirm that I am the patient or am authorized to sign on the patient's behalf.

Date:_____ Time:_____ Patient Name:_____

Date:_____ Time: _____ Patient Signature:_____
(or circle: Parent/Legal Guardian/ Personal Representative)

Date:_____ Time: _____ Witness Signature: _____

Interpreter Assistance: If an interpreter assisted, please complete the following: Language: _____

Date:_____ Time: _____ Interpreter Name: _____ ID #: _____

For Advocate Personnel Use Only
Brochures Offered:
Notice of Privacy Practices: ☐ Accepted ☐ Declined Patient Rights ☐ Accepted ☐ Declined
Payment Policy: ☐ Accepted ☐ Declined

Date:_____ Time: _____ Signature: _____

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