Advocate Health Care | Aurora Health Care

Patient Name: _____

MRN: _____

Date of Birth: _____

or Affix Label

Health Care Consent

1. **To Treat:** I, for myself (for 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. This 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 or by telehealth services. I understand that health care practitioners in training, may, under the supervision of appropriate personnel, participate in my treatment.

   I further understand, especially in emergency situations, treatment may have been initiated before my ability to review and sign this form. I acknowledge and understand all terms of this form, including but not limited to paragraph 15 regarding Independent Physician/Practitioner Services, are in full effect for the entire duration of the patient's care and treatment at the Hospital. By signing below, I agree to accept the terms outlined in this form including but not limited to paragraph 15 retroactively, even if I had a contrary assumption or understanding about the employment status of any medical practitioner prior to my review and signing of this form.

2. **Coordination of Care:** I understand that Advocate Health Care and Aurora Health Care are now part of Advocate Health, a clinically integrated health system that is comprised of multiple legally independent hospitals, medical groups, and other health care provider entities that all work together to ensure efficient coordination of patient care. I understand that Advocate Health 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 system.

3. **Photography:** I understand that my medical providers may take photographs, video and/or audio recordings to document a medical condition, help with the diagnosis and/or treat a condition, and/or help plan the details of surgery. I understand that my medical providers or the Hospital will retain the ownership rights to these photographs, videos and/or audio recordings. I also understand 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. The Hospital will generally use Advocate at Home to allow for continuity of care unless directed by my insurance carrier or I select a different provider. A list of home care providers is given 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 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:** I have been provided information regarding translation and interpreter services. I understand these services are available at no cost, and I may request these services at any time during my admission.

7. **Release of Medical Information for Payment:** I hereby consent to the release of 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.

8. **Electronic Communications:** I authorize Advocate Health and its representatives (including third-party agents) to contact me by phone using pre-recorded messages and/or automated dialing systems at any phone number associated with me or my personal representatives in connection with any matter relating to my treatment, payment, account, research activities, or to advise me of products or services that may be of interest to me. I can only decline to receive further calls or messages by following the instructions specifically provided by Advocate Health. I understand I am not required to agree to receive phone calls and messages to receive treatment or other Advocate Health services. By providing an email address and cell phone number, I give permission for Advocate Health (including its independent contractors) to send me information, reminders, and messages using those means of communication for the reasons outlined 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 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.
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 I hereby release the Hospital of responsibility and all liability for those valuables and items of personal property which are not kept in a Hospital safe, including for any damage to personal property or lost items.
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 the Hospital bill does not include independent physician/practitioner services, and the patient will receive separate bills from those medical providers for their services.** I am aware that some physicians may not participate in the health plan or payment program that pays for my care and, thus, I may be subject to additional charges. 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 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 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 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. **Appointment and Release for Coverage Purposes:** I appoint Advocate Health and its financial counseling or coverage assistance personnel (the "Representative") as my and the patient's agent and representative for purposes of exercising, in its discretion, any or all rights and responsibilities I or the patient may have or later acquire related to pursuing, disputing, receiving, enrolling in, disenrolling from, requesting continuation of, or appealing benefits or health coverage that are funded with local, state, or federal funds including programs under the Social Security Act including but not limited to Medicaid and Medicaid waivers ("Assistance"). The Representative is also authorized to access and inspect, and shall receive copies of any records, information, or notices to which I or the patient may be entitled, including but not limited to financial, tax, employment, insurance, health, and other information that may relate to Assistance as well as denial notices, approval notices, requests for information, adverse benefit

determinations, and notices of resolution. I authorize the Representative, at his/her discretion and own expense, to obtain legal representation, which shall have the same authority as the Representative. If the Representative has already taken actions consistent with this authorization and release, I have reviewed and ratify those actions. This appointment and authorization for coverage purposes remains effective until revoked by me or the patient in writing delivered to the Representative and shall not be impaired by my or the patient's death or incapacity.

14. **Payment Obligation and Guaranty:** I agree to pay all charges of Advocate Health for services received by the patient. This contractual obligation and guaranty requires payment in full for all services provided, including but not limited to all Advocate Health charges the patient incurs in accordance with Advocate Health's regular rates and terms as set forth in the "chargemaster" in effect at the time of treatment that Advocate Health is required to maintain pursuant to 42 U.S.C. § 300gg-18(e). For clarification, such contractual obligation and guaranty each require payment of all charges that are not covered by insurance, regardless of the reason that insurance coverage is denied. If I fail to pay such charges and Advocate Health or any other person or entity to which I owe payment uses an attorney to collect unpaid charges, I agree to pay the reasonable cost of the attorney's services in addition to the unpaid charges. I consent and authorize Advocate Health and the non-employed physicians/practitioners to contact outside data sources of its choosing, including credit reporting agencies to evaluate and assess my credit worthiness, my financial assistance eligibility, and the viability of collecting any amounts due from me, whether at this time or on subsequent visits. I understand and agree that Advocate Health may assign accounts as it deems necessary for purposes of collecting any amounts owed, including to collection agencies and attorneys.

15. **Legal Notice about Independent Physician/Practitioner Services:** I acknowledge and fully understand the following: The physicians and other medical practitioners (or "practitioners") who provide medical services to me at this Hospital **ARE NOT EMPLOYEES OR AGENTS OF THE HOSPITAL OR ADVOCATE HEALTH, BUT ARE INDEPENDENT CONTRACTORS OR INDEPENDENT PRACTITIONERS.** These independent contractors/practitioners include but are not limited to physicians and other medical providers like physicians' assistants, certified registered nurse anesthetists, nurse practitioners, and nurses. Only those Physicians/Practitioners who explicitly and clearly identify themselves as hospital employees are the employees or agents of the hospital. Independent physicians/practitioners are required to wear security ID badges that say Advocate Health and/or identify the specific name of the Advocate hospital/facility. These badges are not used to identify the employment status of any physician/practitioner and are exclusively used for security purposes. I understand that I should ask my physician/practitioner any questions I may have about their employment status.

    Non-employed physicians/practitioners are permitted to use the Hospital to provide medical care and treatment to their patients. **Non-employed physicians/practitioners include, but are not limited to, my primary care physicians, my attending physicians, the physicians' assistants, certified registered nurse anesthetists, nurse practitioners, nurses, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology, and other specialties not listed.** The Hospital and Advocate Health do not control the medical decisions made by these independent physicians/practitioners. These independent physicians/practitioners exercise their own independent medical judgment in treating me or otherwise providing professional services to me and are solely and legally responsible for their own care and treatment. The Hospital and Advocate Health are not legally responsible for the care and treatment provided by these independent physicians/practitioners. I will receive and will be solely responsible for paying a separate bill from each of these independent physicians/practitioners for the care and treatment they provide.

    My decision to seek medical care at the Hospital or Advocate Health is NOT based upon any understanding, representation, advertisement, media campaign, inference, presumption, or reliance that the physicians/practitioners providing care and treatment to me are employees or agents of the hospital or advocate health because, as described above, they are not unless they explicitly and clearly tell me otherwise.

    Patient/Representative Initials: _____

Patient Name: _____

MRN: _____

Date of Birth: _____

or Affix Label

16. **Notice of Privacy Practices and Patient Rights:** I acknowledge that the Hospital has provided me a copy of its Notice of Privacy Practices, and Patient Rights. I understand the Notices describe the Hospital's privacy practices regarding the use and/or disclosure of health information, the Hospital's payment policy regarding charges for Hospital services, collection, charity care and payment assistance programs, and other patient rights. I may not have elected to retain these brochures.

    By my signature below, I confirm that I acknowledge and understand that the Hospital uses independent contractors or independent practitioners to provide various services as described above. I further acknowledge that I have read this consent form, including the specific language related to the independent physician/practitioner services, and have had the opportunity to ask questions, and that any questions have been satisfactorily answered. I also acknowledge my signature on an electronic platform may appear different from my actual signature but confirm my signature is valid, binding, and enforceable.

Date	Time	Signature of Patient	
Date	Time	Signature of Legally Aurhotized Agent	Relationship to Patient

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

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