

GENERAL CONSENT

I. CONSENT FOR DIAGNOSIS, CARE AND TREATMENT. I consent to and authorize my attending physician, other physicians and healthcare professionals who may be involved in my care, and Northwestern Memorial Hospital (the Hospital), its employees and agents, to provide such diagnosis, care and treatment considered necessary or advisable by my physician(s). I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me about the result of my examination or treatment at the Hospital. I understand that Northwestern Memorial Hospital is a teaching hospital and that physicians, nurses and other healthcare professionals in training will be involved in my care and treatment.

II. PHYSICIANS' RELATIONSHIP TO HOSPITAL– PHYSICIANS ARE NOT EMPLOYEES OF THE HOSPITAL. I understand that the physicians providing services to me at Northwestern Memorial Hospital are not employed by the Hospital and that the Hospital does not control or direct their care of patients. **Physicians are independent medical practitioners** who are permitted to use Hospital facilities for the care and treatment of their patients. This includes, but is not limited to, my treating and consulting physicians, Emergency Department physicians, radiologists, pathologists, anesthesiologists, other specialists and any allied health care providers they employ. **My decision to seek care from Northwestern Memorial Hospital is not based upon any understanding, representation or advertisement that the physicians treating me are employees, agents or apparent agents of the Hospital.** I also understand that I have the opportunity to request that my own physician participate during my care at Northwestern Memorial Hospital.

III. USE OF EXCESS SPECIMENS. As part of an academic medical center with Northwestern University's Feinberg School of Medicine ("FSM"), the Hospital participates in medical education and research activities. I agree that any excess tissue, fluids or specimens removed from my body during my outpatient visit or hospital stay ("my specimens") that would otherwise be disposed of by the Hospital may be used for such educational purposes and research, including research on the genetic materials (DNA). I understand that any research on my specimens will be done in a way that will not identify me. I also understand that there are no plans to compensate me in the event that such research involving my specimens results in new inventions that have commercial value.

IV. HEALTH INFORMATION. I understand that the Hospital will record medical and other information related to my diagnosis, care and treatment (referred to in this form as "my health information") in electronic, video, photographic, audio and other forms. I consent to production and internal use by the Hospital of any videotape, photographs, audio records and other images containing my health information for education and healthcare operations as defined in the Hospital's Notice of Privacy Practices.

A. TREATMENT AND CONTINUITY OF CARE. As applicable, I consent to the following actions by the Hospital relating to my health information when my consent is required by law:

- contacting other healthcare providers, such as physicians not on staff at the Hospital, other hospitals, nursing homes, home health agencies, and pharmacies, to obtain information about my prior and current health conditions for treatment at Hospital;
- disclosing my health information to other healthcare providers, such as physicians not on staff at the Hospital, other hospitals, nursing homes, home health agencies, as necessary for treatment, continuity of care and discharge planning purposes.

B MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/ALCOHOL AND DRUG ABUSE/HIV/AIDS/GENETIC TESTING & COUNSELING. As applicable, I consent to the following uses within and disclosures outside the Hospital relating to records of my treatment for mental health and developmental disabilities, alcohol and drug abuse, HIV, AIDS, and genetic testing and counseling when my consent is required by law:

- contacting other healthcare providers as described in Section A above to obtain such health information as needed for my treatment at the Hospital, and disclosing such information to other health care providers as necessary for treatment, continuity of care and discharge planning purposes.
- using such health information internally, or disclosing such information to FSM as the Hospital's records custodian, to support healthcare operations as defined in the Hospital's Notice of Privacy Practices, which includes reviewing and improving the quality, effectiveness and cost of care.
- sharing such health information between and among the Hospital and physicians on staff at the Hospital with whom I have a treatment relationship, and their employees, for treatment, continuity of care, billing for services provided, improving quality of care, reviewing the qualifications of or training healthcare professionals, or addressing fraud and abuse issues.
- disclosing such health information, to FSM as records custodian for research purposes as described in the Hospital's Notice of Privacy Practices. I understand that information that identifies me will be removed and my health information will be used in a way that does not identify me. I further understand that my care and treatment will not be affected if I do not consent to this disclosure. More information about research at FSM is available at 312-503-9338.

I agree that my consent to disclose my health information in this Section IV(B) shall apply to all health information in the Hospital's possession, even if I am diagnosed or treated for such conditions for the first time during this visit or a later visit while this consent is in effect. I may revoke my consent set forth in Section IV(B) to disclose my health information relating to my treatment for mental health, developmental disabilities, HIV or AIDS, and genetic testing and counseling by providing written notice to the Hospital. My written revocation shall not apply to disclosures already made by the Hospital based upon the above consent. If not revoked, the above consent will expire 5 years from the date below. I understand that I have the right to inspect and copy any information to be disclosed regarding mental health, developmental disability, alcohol and drug abuse, HIV tests, genetic tests or genetic counseling services, and that such information may not be re-disclosed by any recipient without my further consent or as required by law.

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V. PERSONAL PROPERTY. I understand that I should not bring valuables to the Hospital and that the Hospital will not be responsible for the loss, destruction or theft of my personal property. I am aware that there may be storage options available at the Hospital for my use. I assume full responsibility for all my personal property, including but not limited to my clothing, money, jewelry, glasses, dentures, hearing aids or other personal items. I release the Hospital from responsibility and liability for such personal items and valuables.

VI. FINANCIAL RESPONSIBILITY

A. RESPONSIBILITY FOR PAYMENT. In consideration of the services provided at the Hospital, I agree to pay the Hospital, my physician(s) and other professionals involved in my care for all services, facilities and supplies provided to me. The Hospital's bill will be based upon the current rates contained in the Hospital Charge Master, which is a list of charges for Hospital services, supplies and facilities. I understand that more information about my Hospital bill can be found in the Hospital brochure regarding patient billing and financial assistance.

If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover my treatment, I authorize the Hospital to bill any such insurer for all hospital and medical services provided. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment or charges not covered by my health insurance, Medicare, Medicaid or any other programs for which I am eligible. The Hospital will then bill me for the amount that is my responsibility according to my insurance plan, and I will be responsible for paying that amount. I will not be responsible for any charges over the payor rate contracted with the Hospital, except for any applicable deductible, co-payment, or non-covered charges.

B. ASSIGNMENT OF BENEFITS. I hereby assign to Northwestern Memorial Hospital, my physician(s) and other healthcare professional(s) involved in my care, all my rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which benefits may be available to pay for the Hospital and medical services provided to me. I agree to cooperate and provide information as needed to establish my eligibility for such benefits. If I claim benefits under Title XVIII of the Social Security Act, I hereby certify that the information I provide in applying for payment of such benefits is correct.

C. RELEASE OF INFORMATION FOR BILLING AND BENEFITS. As applicable, I consent to the release by the Hospital of my health and other information, including information regarding my treatment for mental health, developmental disabilities, alcohol and drug abuse, genetic counseling, HIV or AIDS, to any private health insurance plan, Medicare, Medicaid, other governmental insurance program, other third-party payor or benefits provider that I identify, or their agents, as needed for the Hospital to obtain payment for the treatment and services provided to me. In the event that I have been requested to but do not consent, or later revoke my consent, to the release of my health information to an insurer or other third party I have identified, I understand that I will be responsible to pay for the treatment and services received.

D. FAIR PATIENT BILLING ACT NOTICE. The Hospital is required by Illinois law to advise me that:

- I will receive a separate bill for the services provided to me by the physician(s) and other healthcare professional(s) involved in my care.
- My physician(s) and other healthcare professional(s) involved in my care may not be participating providers in my insurance plan or network and I may have greater financial responsibility for their services if they are not under contract with my health plan.
- Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan and my certificate of coverage.

E. FINANCIAL ASSISTANCE. If I am uninsured or am having difficulty paying my Hospital bill, I understand the Hospital has many financial options that may be of assistance, including free care, discounted care or interest-free payment plans. I understand that I will be required to provide financial information to determine my eligibility for these programs. The Hospital's financial counselors can help me apply for these programs or simply answer questions about my bill. Financial counselors can be reached toll free at 800-423-0523.

I HAVE READ and fully agree to each of the statements in this form and sign below as my free and voluntary act. I understand that I may make changes to Sections III, IV VI (B) and (C) above. The Hospital will not be bound by any other changes I make to this form. I also acknowledge receipt of the Hospital brochure regarding patient billing and financial assistance.

_____	_____
Patient Name/Signature	Date
_____	_____
Parent/Guardian/Legal Representative/Guarantor (circle one)	Date
_____	_____
Witness/Signature	Date