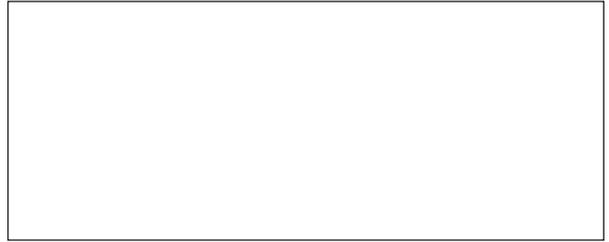


CONSENT FOR CARE AND SERVICES

(11/2022)



Please read this form carefully. This “Consent” form explains how we provide care, share your information, receive payment for the services provided, and perform certain business functions. Unless it is an emergency, you must sign this form before receiving care. We cannot accept any changes to this form.

My Consent for Care and General Terms

Who We Are: In this Consent, the term “EEH” “we” or “us” means: Edward-Elmhurst Health (including, but not limited to, Edward Hospital, Elmhurst Memorial Hospital, Linden Oaks Hospital, Edward Health Ventures and any other EEH patient care location), certain organizations owned or controlled by us or our parent NorthShore – Edward-Elmhurst Health (the “Affiliates”) including, NorthShore University HealthSystem, Swedish Hospital, Northwest Community Healthcare, and the physicians, nurses and other staff or employees of EEH and the Affiliates.

Providing Care: I give my consent for EEH to provide care to me or the person designated below (“me”, “my” or “I”). I understand that care means all medical services, including, but not limited to, examinations, treatment, administration of medications, blood or immunizations deemed necessary and appropriate to treat my condition or illness, and diagnostic procedures. Care may also include mental health evaluation and treatment. If I am pregnant, I agree that all the provisions in this Consent also apply to my unborn child/children for their care while I am receiving care from EEH.

I understand that this form authorizes any reasonable medical action taken for any purpose while I receive care with EEH, 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. I understand that no guarantees have been made to me about the result of my examination or treatment.

I understand that EEH’s mission is fostered through the training of healthcare professionals. I agree that physicians, residents, fellows, nurses, technicians, representatives from medical and device manufacturing companies who provide support and other healthcare professionals in-training may be actively involved in my care and treatment.

Independent Physician/Provider Services: EEH DOES NOT EMPLOY, CONTROL OR DIRECT THE MEDICAL CARE OF THE INDEPENDENT PHYSICIANS ON ITS MEDICAL STAFFS. I understand that all of the physicians treating me at the EEH Hospitals are independent physicians and are not agents or employees of EEH, except those from Edward Health Ventures (EHV), Edward-Elmhurst Medical Group (EEMG) and Linden Oaks Medical Group (LOMG). I understand that physicians from the following independent physician groups are not agents or employees of the EEH Hospitals and I also understand that this list may not be all-encompassing: Elmhurst Primary Care Associates, Elmhurst Medical Associates; Elmhurst Memorial Physician Service (EMPS); Orthopedic Specialists, S.C.; DuPage Valley Anesthesiologists, LTD., ; Elmhurst Anesthesiologists, P.C.; Naperville Radiologists, S.C.; Elmhurst Radiologist, S.C.; Associated Pathology Consultants of Elmhurst, S.C.; and Laboratory & Pathology Diagnostics, LLC. By initialing below this paragraph and signing this form, I acknowledge that independent physicians

are not employed, supervised, or controlled by EEH. I understand that each of these independent physicians have staff privileges but treat patients based upon their own independent medical judgment and that each independent physician, not EEH, is solely responsible for the care, treatment, and services that they order, request, direct or provide. I understand that I should ask each of my physicians any questions I may have about their employment status. I further acknowledge that the employment or agency status of the physicians who treat me is not relevant to my selection of EEH for my care. I also understand that I will receive a separate bill from each of these independent physicians for their services and I am solely responsible for such bill.

_____ (Patient or Personal Representative Initial)

Language Assistance: If applicable, I have identified my preferred language and whether I require qualified interpreting or other language assistance services during registration. I understand that qualified interpreting and other language assistance services are available to me at no cost and, if I did not elect to have language assistance services at registration, I may request these services at any time during my visit by notifying a member of the patient care team.

Advance Directive: I acknowledge that I have the right to formulate an advance directive and to have EEH comply with these directives. If I have provided EEH with a copy of my advance directive, EEH will honor my expressed wishes and directives as fully and as reasonably possible, and in accordance with Illinois law. My access to care, treatment, and services, however, is not dependent upon whether I have an advance directive.

Photography and recordings by patients: I understand that I am not allowed to take pictures or to record care or treatment provided by EEH. To respect the privacy of other patients, I understand that I am also not allowed to take pictures or record other patients.

Photography and records by EEH: I understand that EEH and my individual provider(s) 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 care. I give permission for EEH to take photographs, videos, digital and other images or recordings of me for treatment, education and operational purposes. I also give permission for EEH to use and disclose non-identifiable images externally for these purposes without additional authorization. Further, I understand that the photo from my State issued ID or Driver's License will be used in EEH's electronic health record for my protection and to prevent identity theft. I understand that all reproduction and all copyrights associated with these images and media are and shall remain the property of EEH, its successors and/or assigns. **Personal Property:** I understand that EEH is not responsible for the loss, theft, or destruction of my personal property, including valuables that I bring with me to EEH. I release EEH from responsibility and liability for the loss, destruction, or theft of any personal property that I bring with me to EEH.

Property Damage: I understand that I am responsible and accept liability for any damage to or destruction of EEH property or property belonging to others that is caused by the patient.

Expiration and Revocation: If I have rights under the law, I may revoke my permission to share my Health Information (as defined below), and this Consent, by writing to EEH's Health Information Management Department at: Department of Health Information Management, 801 South Washington Street, Naperville, IL 60540 or by calling 331-221-0714. I understand that if I revoke my permission to share my Health Information, it will not apply to any actions taken by EEH while this Consent was effective.

Using and Sharing My Information

The Law: There is a federal law called the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). This law requires EEH to protect the privacy and security of its patients’ treatment, contact, and financial information. Taken together, this information is called your “Health Information”. There are also other federal and/or state laws that require EEH to take additional steps to protect certain categories of Health Information, including, but not limited to, Health Information about behavioral or mental health; developmental disabilities; treatment for substance abuse (alcohol and/or drugs) disorders; genetic testing and counseling; HIV/AIDS; sexual assault/ abuse; sexually transmitted illnesses; pregnancy; birth control; domestic abuse of an adult with a disability; child abuse and neglect.

Patient Rights, Authorization and Notice of Privacy Practices (“NPP”): If my permission is required by law, by signing this form I agree that EEH may receive, use and disclose my Health Information as set forth in this Consent and as set forth in the NPP. I understand that I can find more information about my rights to my Health Information, and about how EEH uses my Health Information, in the NPP. I acknowledge that I received a copy of the NPP and the Patient Rights and Responsibilities. I further understand that the NPP and the Patient Rights and Responsibilities are available on EEH’s website at: www.eehealth.org.

I agree that my permission applies to all of my Health Information in EEH’s possession, including but not limited to my contact information, diagnostic test results, problem and medication list, medical history, and other clinically relevant data.

I understand that EEH cannot control how others that receive my Health Information will protect or use my information. I understand that others may not be required by law to protect my Health Information.

I understand that if a patient is between the ages of 12 and 18 years old, Illinois requires that the patient must also give permission by signing this form, as appropriate.

Purposes for which my Health Information may be shared: I understand that EEH may receive, use, and disclose my Health Information for the purposes outlined in the NPP. In particular, EEH may use and disclose my Health Information for the following purposes:

Immunization Tracking Purposes: I-CARE is an immunization record-sharing computer program developed by the Illinois Department of Public Health. I-CARE helps health care providers record, track and report their patients’ immunizations. Participation is voluntary. If I prefer not to participate, I must complete an opt-out form at the time of registration.

Data Sharing Program Purposes: “Other Providers” also may include my providers participating in data sharing programs such as: Epic CareEverywhere®, Epic CareEquality, EpicCare® Link, or other similar data sharing programs not listed here. These data sharing programs allow my providers to exchange my Health Information for treatment purposes, including in emergency situations. I give my permission to EEH to send and receive my Health Information electronically with my other providers. If I prefer not to participate, even in an emergency, I must notify EEH’s Health Information Management Department by calling 331-221-0714.

Operational Purposes: I agree that the contact information I give to EEH, such as telephone numbers

and email addresses, may be used by EEH and third parties acting for EEH to communicate with me for operational purposes including appointment follow up, treatment reminders, and patient surveys. I agree that such contact information I provide to EEH may be used by EEH or those acting on its behalf to communicate with me by telephone (including mobile phone), text, or automated or prerecorded messages. If I do not want to receive text messages or phone calls, then I must notify the MyChart Help Line at 630-527-5070.

If I change my phone number, I need to notify EEH immediately by calling the MyChart Help Line at 630-527-5070. I know that I am under no obligation to authorize EEH, its agents, its affiliates, or its third-party vendors to send me text messages. I may opt-out of receiving these communications at any time by responding STOP to text messages. If I still am receiving the text messages, I will call the MyChart Help Line at 630-527-5070. I understand that it may take, at minimum, five (5) business days for processing. I understand and agree that I may receive information via text messages which may include but is not limited to lab result notification, appointment reminders, procedure reminders, virtual waiting room notifications, medication reminders, diagnostic testing notification, health reminders, marketing messages, surveys and other healthcare related communications.

I understand that text messaging is not a secure format of communication. I understand that there are risks associated with text messages such as individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties and I assume all the risks.

By signing below, I indicate I am the primary user and subscriber or have consent from the subscriber for the mobile phone number provided to EEH. I accept all risks and I consent to receive text messages from EEH, its agents, its affiliates, and its third party vendors to the phone number that I have provided.

Marketing Purposes: I further agree that the contact information I give to EEH may be used by EEH and third parties acting for EEH to communicate with me for commercial, advertising or marketing activities, including collection or billing matters. I understand and expressly consent to be contacted by auto-dialed and/or artificial or pre-recorded text messages or telephone calls or voicemails at the number I provided to EEH. I understand that my consent is not required as a condition of purchasing or receiving any goods or services from EEH. If I desire to revoke my consent, or do not want to be contacted for marketing purposes, I must notify EEH at www.eehealth.org/contact-us/.

Research Activities: I understand that EEH's mission includes advancing knowledge and scientific discoveries through research. Providers and/ or researchers may contact me to discuss research opportunities that may be of interest to me. It is my decision whether I agree to participate.

I understand that EEH may use and share my excess tissue or body fluid for educational and research purposes in accordance with law. Further, I understand any rights including, but not limited to, economic, research, and/or property rights, relating to such specimen or tissues remain with EEH.

Financial Acknowledgments

Payment for Care: I understand that by signing this form, I agree that EEH will bill my health insurance for the cost of my care. In exchange for the care provided, I assign and transfer and set forth my rights, title and interest to any and all medical reimbursement under my insurance policy, subscription certificate or other health benefit coverage agreement otherwise payable to me to EEH.

I give my permission for EEH to release all medical information, including HIV, that may be necessary for the payment on my behalf for the health care services rendered to the patient named in this Consent.

I understand that insurance coverage varies and that my insurer may not pay for everything or may pay only part of my bill. I understand that my insurer may deny payment for services that are not covered by my plan, or that the insurer decides are not “medically necessary,” “experimental,” or not covered. While EEH may take reasonable steps to appeal these denials, I understand that I am fully responsible for payment of all charges not covered by medical insurance.

I agree that I am responsible for any expense of EEH in collecting the amounts guaranteed hereby, including all court costs, reasonable attorneys’ fees, and all other expenses. I authorize EEH to file a lien, or any other action permitted under Illinois law, to obtain full payment for the services provided.

Billing Providers: As required by the Fair Patient Billing Act, I understand that care and services provided at any EEH facility may include any of the EEH and Affiliates providers, including all of their physicians, nurses and staff. I understand that each provider may bill me separately.

I understand that EEH cannot guarantee that a service will be covered under my health plan. I understand that it is my responsibility to contact my insurance company to determine whether a provider or hospital service will be covered by my insurance. I also understand that I should ask my physician any questions I may have about his/her employment status with EEH and whether he/she participates in the same insurance plans as EEH. I understand that if I receive “out-of-network” services, I may have greater financial responsibility to EEH for payment for these services.

I understand that even if a service is covered, or partially covered, by my insurance plan, I may still be responsible for part of the cost. It is my responsibility to contact my insurance company to determine the cost of the service I will be required to pay.

ERISA: If my insurance benefits are provided through an ERISA plan or other employer group health plan, and if permitted under the plan terms, I assign, transfer, and set forth all my rights, title and interest as a beneficiary of the plan to EEH, for my care. I also appoint EEH as my authorized representative to receive plan coverage information and appeal any rights to payment and healthcare benefits. I agree to cooperate and provide information as needed by EEH to establish my eligibility for my insurance benefits.

Medicaid/Medicare: If I am seeking services to be covered under Medicare or Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for provider services to the provider(s) or organization furnishing the services or authorize them to submit a claim to Medicare or Medicaid on my behalf.

Financial Assistance: If I do not have health insurance or have difficulty paying my bill, EEH provides eligible patients financial assistance options, including free care, discounted care or interest-free payment plans. Information about financial assistance, qualification criteria and whether or not my physician or other providers offer financial assistance is available to me upon request by calling the Patient Accounts Department at 888-328-6087.

By signing below, I confirm that I have read, understood and agreed to the contents of this form, the Consent, including the specific language related to independent physician services. I have been able

to ask questions, and all of my questions have been answered to my satisfaction.

This Agreement is written in English. If this Agreement is translated into any other language, the English version shall control.

All required signatures must be provided for the form to be valid:

Signature of Patient (age 18 or older) or Personal Representative **Date/Time**
Relationship to Patient (check one): _____ *Self* _____ *Parent* _____ *Guardian* _____ *Legal Representative*

Signature of Minor Patient (age 12 to age 17) **Date/Time**

Signature of Witness or Employee **Date/Time**

Signature/Name of Interpreter (if applicable) **Date/Time**