

**EDWARD-ELMHURST MEDICAL GROUP AGREEMENTS AND AUTHORIZATION****CONSENT TO HEALTHCARE SERVICES**

- 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.
- I, (the Patient signing below, or person signing below who is responsible for consenting on Patient's behalf) request and consent to all care, treatment, and other services that may be ordered, requested, directed, or provided by physicians, or their associates, assistants, or designees, and carried out by physicians or personnel at EEH and the Affiliates.
- I understand that I have the right to refuse this care, treatment, or other services, if refusal is allowed under the law.
- I understand that the practice of medicine is not an exact science. I understand and agree that no guarantees have been made, or can be made, as to the result of diagnosis, treatments and medications, tests or examinations provided at EEH and the Affiliates.
- I consent to photographs or other recordings to be used for the purpose of treatment, quality assurance, or education. I understand I have the right to refuse such recordings.
- A valid photo ID is required for all patients 18 and over. For patients under 18 we require a parent's valid photo ID. The photo from your State Issued ID or Driver's License will be used in our system EHR for your protection and to prevent identity theft. If you do not present with a valid photo ID at the time of your visit, you may be asked to reschedule your appointment.

**TELEMEDICINE VISITS**

- Telemedicine is the practice of medicine that involves the use of electronic communications to diagnose or treat patients located in Illinois who are in different locations from their healthcare providers ("Telemedicine"). Telemedicine also enables healthcare providers at different locations in Illinois to share individual patient medical information for the purpose of improving patient care. Telemedicine technologies include but are not limited to video teleconferencing, live video, storing images and other telecommunication devices or applications.
- By executing this form, I, as patient or patient's legal representative, ("Patient") consent to the utilization of Telemedicine technologies in the course of my medical treatment and authorize EEH and the Affiliates and its employed and/or contracted providers to provide me with Telemedicine services. By signing below, I understand that Telemedicine services are not always a substitute for in-person visits and have limitations because no physical exams can be performed. I also affirm that I will be in Illinois when such Telemedicine services are requested.

**CONSENT TO RECEIVE TEXT MESSAGES**

- I authorize EEH, its Affiliates, its agents, and its third-party vendors to contact me via text messages. I understand that message/data rates may apply to text messages sent by EEH, its Affiliates, its agents, and its third-party vendors under my cell phone plan. I have an affirmative responsibility to notify EEH if my text/mobile number changes. EEH, its Affiliates, its agents, and its third-party vendors shall not be responsible for any text/mobile messages sent to a text/mobile number that I provide. I shall immediately inform EEH if my text/mobile number has changed. If I change my phone number, I need to notify EEH immediately, by calling Edward-Elmhurst Health Information Management Department at 331-221-0714.
- 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 EEH MyChart Helpline 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, appoint 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 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.

### **PAYMENT GUARANTEE**

- In consideration of the services provided by EEH and/or the Affiliates to Patient, I agree to: i) guarantee payment of all charges that are related to the services provided to the Patient; ii) for all time assign and transfer to EEH and/or the Affiliates all of the Patient's right, title and interest to medical reimbursement benefits that are available to pay for those charges; and iii) authorize payment of these benefits directly to EEH and/or the Affiliates.
- I agree that EEH and/or the Affiliates is not responsible for finding out if the Patient has any insurance or other benefits that may pay for care or services provided to the Patient, or what the extent of the Patient's benefits may be.
- I agree to be fully responsible for the payment of any and all charges if these charges are not covered by the assigned benefits.
- EEH and/or the Affiliates provides many services to assist uninsured patients as well as patients who cannot afford the cost of care. I understand that if I have any questions about EEH and/or the Affiliates financial assistance policy I may ask the office supervisor during the registration process.

### **FOR MEDICARE PATIENTS**

- I certify that any information given by me as the Patient or Patient Representative in applying for payment by Medicare is correct.
- I authorize any holder of medical or other information about Patient to release to Medicare or its agents any information needed for this or a related medical claim.
- I authorize payment of benefits to EEH and/or the Affiliates on the Patient's behalf.

### **RECEIPT OF NOTICE OF PRIVACY PRACTICES**

- I acknowledge that I received a copy of NS-EEH's Notice of Privacy Practices. The Notice of Privacy Practices describes how the Patient's medical information may be used and disclosed by EEH and/or the Affiliates and describes the Patient's rights with respect to this medical information.
- **RELEASE OF INFORMATION FOR PAYMENT:** I authorize EEH and/or the Affiliates to release any and all relevant information about me from my records, including HIV, to any third-party payors responsible for payment of charges, including insurance companies and health benefits plans. I must sign an additional waiver form if I do not want any information regarding my visit shared with my insurance company and understand that I will then become personally responsible for payment for that visit.

### **EPIC CARE EVERYWHERE**

- We participate in Epic Care Everywhere. Care Everywhere allows health care organizations that use Epic electronic health record (EHR) and other participating systems to share your medical records via secure, encrypted connections for purposes of enabling your treating providers to access your medical records when treating you. Care Everywhere allows a treating physician real-time access to his or her patient's medical history, previous diagnoses, results of diagnostic tests (e.g., labs, cardiology, and radiology), medications, allergies, progress notes and other crucial medical information without having to wait for these records to be transferred from one facility to another. We will make your Edward-Elmhurst Health medical record, excluding any records related to your mental or behavioral health treatment, available to other health care organizations through Care Everywhere. When it comes to your PHI, you have certain rights. This section explains your rights and some of our responsibilities to help you. If you do not want your medical record to be shared through Care Everywhere, please contact our Edward-Elmhurst Health Information Management Department at 331-221-0714 and ask them to complete the necessary steps to remove you from the Care Everywhere Program.

**Please turn to page 3 for signature**

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**NO SHOW POLICY**

- I acknowledge that 24-hour notice is required to cancel any appointment, or I may be charged a \$40.00 "No Show" fee.
- I understand that all patient copays and outstanding balances are due at the time of visit.

**No revisions or changes to this form by you will be accepted by EEH and the Affiliates.**

This agreement and authorization form will be signed each time I receive treatment at an Edward-Elmhurst Immediate Care Location. If I am receiving treatment at a Physician Practice or Walk-in Clinic from Edward Health Ventures/Elmhurst Clinic/Elmhurst Memorial Health Care/Elmhurst Memorial Associates/Linden Oaks Medical Group, this agreement and authorization form will be valid for a period of 365 days from the date of my signature below, unless revoked by me in writing sooner, or restricted to a shorter time period by applicable law.

I have read this entire form and any questions I had about this form have been answered to my satisfaction. I understand and agree to its contents.

Patient Name: \_\_\_\_\_  
(Print)

DOB: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient if 18 or over

DATE/TIME: \_\_\_\_\_

\_\_\_\_\_  
OR Patient's Representative  
(Parent, Guardian or other representative if patient is a minor or unable to sign)

\_\_\_\_\_  
Relationship

DATE/TIME: \_\_\_\_\_

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