Authorizations and Agreements

1. CONSENT TO TREAT: I, (the patient signing below, or person signing below who is responsible for consenting on Patient's behalf) consent to medical treatment (inpatient, outpatient and emergency services), diagnostic procedures, administration of medications, blood or immunizations deemed necessary and appropriate to treat my condition or illness rendered to me at Elmhurst Hospital. I understand that physicians, nurses, other health care providers in training, or representatives from medical and device manufacturing companies who provide technical support may, under the supervision of appropriate personnel, participate in my treatment and I consent to their involvement in my care. I consent to photographs or other recordings to be used for the purposes of treatment, quality assurance, or education. I understand that I have the right to refuse such recordings. 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. I authorize Elmhurst Hospital to keep, preserve, or dispose of at their discretion, any specimen, recordings, tissue, parts, or implants taken or removed in the course of providing care.
2. ACKNOWLEDGMENT: 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.
3. **ELMHURST HOSPITAL DOES NOT EMPLOY, CONTROL OR DIRECT THE MEDICAL CARE OF THE INDEPENDENT PHYSICIANS ON ITS MEDICAL STAFF. I understand that all of the physicians treating me at Elmhurst Hospital <u>except</u> the Edward Health Ventures (EHV), Edward Medical Group (EMG), Elmhurst Memorial Medical Group (EMMG), and Linden Oaks Medical Group (LOMG) are independent physicians and are not agents or employees of Elmhurst Hospital. I also understand that the following physician groups listed may not be all encompassing: Elmhurst Clinic, LLC; Elmhurst Medical Associates; Elmhurst Memorial Physician Service (EMPS); Elmhurst Emergency Medical Services, Ltd.; Elmhurst Anesthesiologists, P.C.; Fox Valley Anesthesia Associates, S.C.; Naperville Radiologists, S.C.; Elmhurst Radiologist, S.C.; Associated Pathology Consultants of Elmhurst, S.C.; and Laboratory & Pathology Diagnostics, LLC, physicians are not agents or employees of Elmhurst Hospital. By signing this form, I acknowledge that these independent physicians are not employed, supervised or controlled by Elmhurst Hospital. I understand that each of these physicians has staff privileges but treats patients based upon his/her own independent medical judgment and that he/she, and not Elmhurst Hospital, is solely responsible for the care, treatment and services that he/she orders, requests, directs or provides. I further acknowledge that the employment or agency status of the physicians who treat me is not relevant to my selection of Elmhurst Hospital for my care. I also understand that I may receive and am solely responsible for payment of a separate bill from each of these independent physicians for the care, treatment, or services they provide to me.**

Patient Name:
Date of Service/Admit:
DOB:
MRN:
CSN:

4. RESPONSIBILITY FOR PAYMENT: In consideration of the services provided by Elmhurst Hospital, I agree to guarantee payment of all charges that are related to the services provided to the Patient. I agree to be fully responsible for the payment of any and all charges if these charges are not covered by insurance. I understand that it is my responsibility to check with my insurance carrier to determine whether the costs associated with the services provided to me at Elmhurst Hospital are covered. Failure to pay may result in referral of said account to a commercial collection agency and/or credit bureau. Should the account be referred to any agency or attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. If I receive payment directly for the medical charges associated with my treatment, I acknowledge it is my responsibility to pay such payment to Elmhurst Hospital.
5. ASSIGNMENT OF BENEFITS/INSURANCE ELIGIBILITY: In consideration of those health care services rendered, I hereby assign to Elmhurst Hospital and authorize direct payment to Elmhurst Hospital, any insurance, health plan or third party benefits otherwise payable to me or on my behalf.
6. FINANCIAL ASSISTANCE: Elmhurst Hospital 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 its financial assistance policy I may ask the Financial Assistance Department at 331-221-6740 option 4.
7. FOR MEDICARE/MEDICAID PATIENTS: I certify that any information given by me as the Patient or Patient's Representative in applying for payment by Medicare or Medicaid 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 Elmhurst Hospital on the Patient's behalf. If Patient is a hospital inpatient, I certify that I have been given a copy of "An Important Message from Medicare".
8. RELEASE OF INFORMATION FOR PAYMENT: I authorize Elmhurst Hospital 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, health benefit plans, and governmental agencies. I acknowledge that I must request and complete an insurance restriction 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.
9. 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, 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 331-221-6990 and ask them to complete the necessary steps to remove you from the Care Everywhere Program. If you have previously opted out of Care Everywhere, no further action is required.

Elmhurst

Elmhurst Hospital
155 E. Brush Hill Road
Elmhurst, Illinois 60126
TELEPHONE: 331-221-1000

AGREEMENTS AND AUTHORIZATION

Patient Name:
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CSN:

10. PATIENT RIGHTS AND NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Patient's Rights and Responsibilities and the Notice of Privacy Practices.
11. CONTACT INFORMATION: I give my express consent for Elmhurst Hospital, its providers and agents, including debt collectors, to contact me by telephone at any telephone number provided by me, including cell phone numbers, for any permissible purpose. Methods of contact may include but are not limited to, using pre-recorded/artificial voice messages and/or use of automatic dialing devices.
12. I CARE: I understand that the Patient's immunization information will be sent to the Illinois Comprehensive Automated Immunization Registry Exchange (I-CARE), which is an immunization record sharing system administered by the Illinois Department of Public Health, unless I complete an opt-out form.
13. PERSONAL BELONGINGS: I understand that Elmhurst Hospital is not responsible for any Patient clothing, valuables, or other personal belongings kept with the Patient during his/her visit. I hereby release the facility from any liability for any and all personal possessions kept with the Patient during his/her visit.
14. No revisions or changes to this form by you will be accepted by Elmhurst Hospital.
15. Billing for Elmhurst Clinic, Elmhurst Medical Associates: I acknowledge that I may be receiving one bill from the physician group for the professional service and another bill from Elmhurst Hospital for the facility charges associated with my visit.
16. OUT-OF-NETWORK PROVIDERS: I understand some providers and hospital staff members may not be participating providers in the same insurance plans and networks as Elmhurst Hospital. I may have a greater financial responsibility for services provided by health professionals who are not under contract with my health care plan and these health care professionals may bill me separately. If I have any questions about my coverage or benefit levels I understand that I need to contact my health care plan and review my certificate of coverage.

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.

Date/Time	Signature of Patient or Patient's Representative (Parent or Guardian or other authorized representative)	Relationship

Print Name of Witness

If patient or responsible party did not sign this form, document the reason below and sign below:

Reason ______________________________

Elmhurst

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