

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 and 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. I authorize the Hospital to examine, use, store and dispose of any tissue, fluids or specimens removed from my body during my outpatient visit or hospital stay.

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. ACCESS TO HEALTH INFORMATION. I understand that the Hospital may record medical and other information related to my treatment in electronic, video and other forms and that such information will be used in the course of my treatment, for payment purposes and to support healthcare operations. I give the Hospital and my treating and consulting physician(s) consent to contact other physicians, healthcare professionals, hospitals, nursing homes, home health agencies, pharmacies and other healthcare providers that may have information related to my prior and current health conditions and treatment.

IV. RELEASE OF HEALTH INFORMATION. I acknowledge that my personal health information may be released by Northwestern Memorial Hospital as described in the Hospital's Notice of Privacy Practices and for the purposes outlined in this section. For discharge planning purposes, I consent to the release by the Hospital and my treating and consulting physician(s) of any and all medical information or records concerning my treatment to other healthcare professionals and providers who may become involved in my care such as hospitals, nursing homes or home health agencies, as applicable.

As applicable, I specifically consent to the release by the Hospital of any and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to:

- my treating and consulting physician(s), other healthcare professionals and healthcare providers such as hospitals, nursing homes or home health agencies for continuity of care and discharge planning purposes, and
- any private health insurance plan, Medicare, Medicaid, other governmental insurance program or other third-party payor that I identify to obtain payment for the treatment and services provided to me at Northwestern Memorial Hospital.

I further consent to the use of any and all information, test results and records regarding my treatment for drug or substance abuse, alcoholism, mental health, HIV or AIDS to support healthcare operations, which includes improving the quality, effectiveness or cost of care. I agree that the above consent shall apply even if I am diagnosed and/or treated for one of the above conditions for the first time during this outpatient visit or hospital stay. I understand that I may revoke this consent in writing at any time. My written revocation shall not apply to disclosures already made by the Hospital or my treating and consulting physician(s) while relying upon this consent. If not revoked, this consent will expire two (2) years from the date it is signed. I understand that I have the right to inspect and copy any information to be disclosed regarding any mental health or developmental disability services.

PERSONAL PROPERTY AND FINANCIAL RESPONSIBILITY

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 and release the Hospital from responsibility and liability for such personal items and valuables.

VI. 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 additional information regarding 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 that amount and for any charges not paid by my insurer and I will be responsible for paying them. I also understand and acknowledge 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.
- If I do not consent, or later revoke my consent, to the release of my information to any insurer that I have identified, I will be responsible to pay all list charges for the treatment and services received.
- Should it be necessary for the Hospital to institute legal proceedings to collect payment from me, I understand that I will be responsible for paying reasonable attorney's fees incurred by the Hospital, court costs and post-judgment interest.

VII. 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.

VIII. 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.

I HAVE READ and fully agree to each of the statements in this form and sign below as my free and voluntary act. 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