

Thank you for seeking care from AMITA Health, an integrated healthcare system that includes hospitals, rehabilitation centers, ambulatory care centers, home health, hospice, diagnostic facilities and healthcare personnel. This form authorizes AMITA Health to provide treatment and related functions, contains other important information, and should be reviewed carefully. Except in cases of emergency, you must sign the final page of the form prior to treatment.

**GENERAL CONSENTS AND ACKNOWLEDGMENTS**

I authorize and voluntarily consent to all care, treatment, and other related services (including diagnostic procedures, tests, radiology, anesthesia, emergency care, the administration of fluids and medications, and other nursing, medical, and surgical treatment and care) that is considered necessary or recommended by my treating or consulting physicians (including their associates or designees) and other healthcare providers who are part of my care at AMITA Health (“Practitioners”). I understand that I have the right to consent to, or to refuse to consent to, any particular proposed medical procedure or course of treatment and that, except in emergency circumstances, no substantial medical procedure will be performed on me unless and until I have had an opportunity to discuss the procedure with the applicable Practitioner(s).

I acknowledge that no guarantees have been made, or can be made, regarding any care, treatment, or other related services that may be provided by any Practitioner, or at any AMITA Health facility.

I understand that AMITA Health participates in health care education and consent to the supervised involvement of students, residents, and fellows in my care and treatment.

I authorize AMITA Health to retain, preserve, and use for scientific or teaching purposes (or to dispose of, in AMITA Health’s discretion) any specimen or tissue sample taken in the course of providing care and waive ownership rights to such specimens.

If, in connection with my care or treatment, an employee of AMITA Health or any Practitioner is exposed to my blood or bodily fluids, I authorize and consent to a sample of my blood being drawn and tested for infectious diseases of any nature or description.

I authorize AMITA Health to create recordings and images of me for purposes of treatment, safety, medical research, and education, and I waive ownership rights to these images. I understand that every effort will be made to protect my identity.

I understand that, in certain circumstances, AMITA Health/my Practitioners may use telehealth services. Telehealth is the use of electronic information and communication technologies by a Practitioner to deliver services to an individual when he/she is located at a different site than the Practitioner. I understand that AMITA Health/Practitioners will determine whether my specific clinical needs are appropriate for a telehealth encounter.

**PRACTITIONER EMPLOYMENT STATUS**

**I understand that all Practitioners who provide care, treatment, and other related services to me are INDEPENDENT PRACTITIONERS and not employees or agents of an AMITA Health entity, except for those Practitioners who clearly and explicitly identify themselves as facility employees by wearing an identification badge with the facility name. I understand that each Practitioner is solely and exclusively responsible for the exercise of his/her own independent medical judgment and is solely responsible for the care, treatment, and services that he/she orders, requests, directs, or provides. I acknowledge that the employment or agency status of Practitioners who treat me is not relevant to my selection of AMITA Health for my care, and I neither require nor is it my expectation that any Practitioner providing me with Practitioner services be an employee of AMITA Health. I also understand that I may receive, and am solely responsible for payment of, a separate bill from each of these Independent Practitioners, or groups of Practitioners, for care, treatment, or services provided. By initialing below, I acknowledge that I fully read and understood this paragraph and have had all of my questions or concerns regarding the employment status of my Practitioners satisfactorily answered by AMITA Health.**

Patient/Patient Representative’s Initials: \_\_\_\_\_

**Consent to Treatment and Other Acknowledgements**

Place Label Here

**FINANCIAL AGREEMENT**

I agree to pay for all care, treatment, and other related services provided to me by AMITA Health and Practitioners at AMITA Health facilities. I understand my financial circumstances will not affect the care I receive. I understand AMITA Health offers a variety of financial assistance programs and discounts for which I may qualify if I have difficulty paying my AMITA Health medical bills. No assignment of benefits or acceptance of partial reimbursement shall be deemed a waiver of AMITA Health’s right to require full payment of all amounts associated with such care, treatment, or other related services.

**ASSIGNMENT OF INSURANCE BENEFITS**

I irrevocably assign and transfer to AMITA Health, and to each Practitioner, all health, medical, or other related benefits payable on my behalf under any contract of insurance, including specifically medical payment benefits under casualty insurance (e.g., automobile and homeowners insurance), or from any other source, governmental or private. I authorize AMITA Health and each Practitioner to directly apply for, and to directly receive payment of, any such benefits.

If my benefits are provided under an ERISA plan, I assign, transfer and set forth all of my rights, title and interest as a beneficiary to AMITA Health/Practitioner with regard to my treatment and services. I also appoint AMITA Health/Practitioner as my authorized representative and grant a limited power of attorney to AMITA Health/Practitioner to receive plan coverage information and appeal any rights to payment and healthcare benefits.

I acknowledge and understand that neither AMITA Health nor any Practitioner is responsible for determining the existence or extent of any insurance or other benefits that may be payable for care, treatment, or other service provided to me, and I agree that I am solely responsible for all charges incurred with regard to such care, treatment, and services, regardless of the existence or extent of insurance coverage (including any deductibles or co-payment amounts associated with any such insurance coverage).

**NOTIFICATION CONCERNING OUT-OF-NETWORK PROVIDERS**

I understand that I may receive separate bills for services provided by Practitioners at AMITA Health facilities. I understand that some Practitioners who provide services to me at AMITA Health facilities may not be participating providers in the same insurance plans and networks as AMITA Health, and that I may have a greater financial responsibility for services provided by Practitioners who are not under contract with my insurance plan. I understand that if I have questions about my insurance coverage or benefit levels, I should direct them to my insurance plan.

**PERSONAL POSSESSIONS**

I understand that I am generally responsible for any personal property I bring with me to AMITA Health. Some AMITA Health facilities maintain a safe for storage of valuables, and I may inquire about storage of my valuables (including jewelry, documents, and cash) in such a safe. I acknowledge and agree that AMITA Health is not responsible for any loss or damage to personal property that has not been delivered to AMITA Health personnel for storage in a safe at the AMITA Health facility.

**PATIENT’S RIGHTS AND RESPONSIBILITIES**

I acknowledge that I have received a copy of the statement of Patient Rights and Responsibilities. I further acknowledge that a representative of the AMITA Health facility was available to explain this document to me and that I have asked any questions that I have concerning this document.

**USE AND DISCLOSURE OF HEALTH INFORMATION**

“My health information” includes diagnoses, test results, histories and assessments, medications, treatment plans, treatment status, procedures, clinical notes, discharge information, and other information related to my course of care, and is generally protected by the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). There are additional legal protections for “Highly Confidential Information,” which is my health information relating to sensitive circumstances or sensitive diagnoses such as HIV/AIDS, behavioral or mental health, developmental disabilities, substance (alcohol and/or drugs) use disorder, genetic testing, and sexual assault/abuse. I consent to share my health information and Highly Confidential Information as follows:

**Consent to Treatment and Other Acknowledgements**

Place Label Here

I agree that AMITA Health and Practitioners may use and disclose to and among AMITA Health/my treating Practitioners, and re-disclose outside of AMITA Health, my Highly Confidential Information for treatment, payment, and healthcare operations, in the same way HIPAA allows use or disclosure of my health information for these purposes and as described in AMITA Health's Notice of Privacy Practices. I understand that payment purposes include disclosing my health information, as well as any Highly Confidential Information, to any commercial health insurer, Medicare, Medicaid, or other governmental or private payer that I identify to AMITA Health, unless I have asked that my payer not be notified and I pay for subject items and services out-of-pocket and in full, as described in AMITA Health's Notice of Privacy Practices. I understand that AMITA Health and Practitioners may also use and disclose my health information and Highly Confidential Information without my consent or other authorization as permitted by applicable law and as described in AMITA Health's Notice of Privacy Practices.

I consent to AMITA Health and my treating Practitioners requesting and receiving my health information and Highly Confidential Information from my other treating providers via health information exchanges (entities that store and/or transfer health information electronically among providers for continuity of care) for treatment, payment and healthcare operations of AMITA Health and/or Practitioners. I agree that AMITA Health and/or Practitioners may also share my health information and Highly Confidential Information with my other treating providers outside AMITA Health via health information exchanges for treatment, payment, and healthcare operations, and that further details, including my ability to opt out of this information sharing, is more fully described in AMITA Health's Health Information Exchange Form. I understand that applicable law permits AMITA Health and Practitioners to share my health information and Highly Confidential Information through health information exchanges for certain purposes without my consent or other permission. If I want to restrict release of my health information or Highly Confidential Information through health information exchanges, I understand I need to request and complete the Health Information Exchange Form.

I agree that the consents and other permissions that I gave in this "Use and Disclosure of Health Information" Section apply to all referenced information in AMITA Health's possession, including information concerning care received prior to or after the date on this form, and that I have the right to inspect and copy the information subject to the uses and disclosures described herein as detailed in AMITA Health's Notice of Privacy Practices. I understand that I may withdraw any of my consents in this Section in the future by notifying the Patient Access representatives at the AMITA Health facility(ies) where my health information is stored. I understand that my withdrawal of a consent will not apply to the extent that AMITA Health or a Practitioner has already acted and relied upon the consent. I understand that, if not withdrawn, consents in this Section are effective for fifty years from the date of signature.

**By signing below, I acknowledge that I fully read and understood this section regarding Use and Disclosure of Health Information, have had all of my questions answered, have had an opportunity to request and receive a Health Information Exchange Form, and consent to the request, use, disclosure and sharing of my health information and Highly Confidential Information described in this Section.**

\_\_\_\_\_  
Signature of Patient or Authorized Representative      Printed Name      Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Relationship to patient (check one):*     Self     Parent     Guardian     Other Legal Representative

\_\_\_\_\_  
Signature of Witness      Printed Name      Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Consent to Treatment and Other Acknowledgements**

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**PATIENT NOTIFICATION**

I consent and agree that all mailing addresses, telephone numbers and email addresses I provide to AMITA Health may be used by AMITA Health or those acting on its behalf to communicate with me regarding matters related to AMITA Health’s treatment, payment or operations (e.g., appointment reminders and registration items, insurance information, medical care, wellness programs, or patient experience). I agree that such communications may include traditional or electronic mail, phone calls (including calls to numbers that may have associated charges to me), texts and voicemail messages, and may also rely on the use of automated or pre-recorded/artificial voice messages and/or an automatic dialing device.

**MAINTAINING A SAFE ENVIRONMENT**

I acknowledge that if there is a reasonable concern that I have brought with me prohibited items including alcohol, illegal drugs, or something that may be used as a weapon, AMITA Health personnel may search my room and/or belongings and confiscate and dispose of such items.

**ACCEPTANCE AND SIGNATURE**

I represent that I have read and understand, and am duly authorized to accept and execute, these terms and conditions, and have initialed the above paragraph regarding Practitioner employment status. Except with respect to the consents in the Uses and Disclosures of Health Information Section, this form expires one year after the date of signature. All of my questions have been satisfactorily answered. I understand AMITA Health will not be bound by any written changes I have made to these terms and conditions. I hereby accept and agree to be bound by all of the above terms and conditions, and I may request a signed copy of this document.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ :\_\_\_\_\_  
Signature of Patient or Authorized Representative    Printed Name    Date    Time

*Relationship to patient (check one):* \_\_\_ Self \_\_\_ Parent \_\_\_ Guardian \_\_\_ Other Legal Representative

**Consent to Treatment and Other Acknowledgements**

Place Label Here