Northwestern Medicine®

My Consent to Medical Care

Thank you for seeking care from Northwestern Medicine, the integrated academic health system of Northwestern Memorial HealthCare, including hospitals and physicians ("NM"). This Consent to Medical Care Agreement authorizes NM to provide you medical care, share your health information and receive payment for the service provided. For a listing of all NM locations and physicians, please go to nm.org. Other than in the case of an emergency, you must sign this form prior to treatment.

1. GENERAL CONSENTS AND ACKNOWLEDGMENTS

A. I consent to diagnosis, medical care and treatment that I have agreed to receive and that is considered necessary or recommended by my physician(s) and other healthcare providers. I understand that no guarantees have been made to me about the result of my examination or treatment. *If I am pregnant, I understand that all the provisions in this agreement apply to my newborn child/children for their medical care and treatment.*

B. I understand that NM's mission includes training healthcare providers. Because of this, physicians (such as "residents" and "fellows"), nurses and other healthcare professionals "in training" may be involved in my care and treatment.

C. I understand that NM's mission includes advancing new knowledge. My physician(s) 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. If I prefer not to be contacted, I can contact NM to be removed from the contact registry (630.933.6528).

D. I understand that "physicians" include, but are not limited to, my treating and consulting physicians, Emergency Department physicians, radiologists, anesthesiologists, other specialists and any allied healthcare providers whom these physicians employ. Some of the physicians and their allied healthcare providers are independent medical practitioners who are not employees or agents of NM, but who are permitted to use NM hospital facilities for the care and treatment of their patients. NM hospitals do not control or direct a physician's care of his or her patients.

E. I understand that NM will not be responsible for the loss, destruction or theft of any personal property that I bring with me to NM. I take full responsibility — and release NM from responsibility and liability — for my personal property.

F. I agree that all telephone numbers and email addresses I provide to NM may be used by NM or those acting on its behalf to communicate with me by telephone (including cell phone), text, or any automated or prerecorded messages.

G. I understand that I am not allowed to take pictures or make video or audio recordings of my care, other patients, NM employees, physicians and students in NM facilities.

H. I understand that NM's mission includes research. I agree that NM may use and share my excess tissue or body fluid for educational and research purposes with or without my personal identification in accordance with law.

I. I understand that NM may contact me to discuss my philanthropic interests. NM provides care to patients regardless of the patients' ability to pay. NM is committed to the health of the communities that it serves by delivering a broad range of programs and services. If I prefer not to be contacted to discuss my philanthropic interests, I can contact NM to be removed from the contact registry (312.926.2033).

2. MY HEALTH INFORMATION

A. I agree that NM can create recordings and images containing my health information for treatment, education and NM operations as described in the NM Notice of Privacy Practices.

B. If I am an obstetrical patient, I understand that NM may use and release my health information for the care and treatment of my newborn child/children, for related payment and NM operations. I understand that my health information will be included in my newborn child/children's medical records.

C. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a law that protects the privacy and security of my health information anywhere in the United States. There are other federal laws, as well as Illinois state laws, that protect "special" health information including information relating to HIV/AIDS; behavioral or mental health; developmental disabilities; treatment for substance (alcohol and/or drugs) use disorder; genetic testing and counseling; artificial insemination; sexual assault/abuse; domestic abuse of an adult with a disability; child abuse and neglect; and, if I am a minor, sexually transmitted illnesses, pregnancy and birth control.

D. If my consent is required by law, I agree that NM may use and disclose my special health information within NM for treatment, payment and NM operations in the same way that HIPAA and other laws allow NM to use or disclose my other health information for these purposes and as described in the NM Notice of Privacy Practices.

E. If my consent is required by law, I also agree that NM may further re-disclose my special health information (1) to researchers for research purposes in accordance with law and as described in NM's Notice of Privacy Practices, (2) to regulators for required disease or other state law reporting; and (3) to non-NM providers for treatment, payment and healthcare operations purposes. "Non-NM" providers may include (but are not limited to) Ann & Robert H. Lurie Children's Hospital of Chicago and its affiliates, as well as providers participating in the Epic Care Everywhere® program as described further in the NM Notice of Privacy Practices (unless I have otherwise opted not to participate in the Care Everywhere program), EpicCare® Link, Epic Carequality or similar programs allowing for the exchange of health information between providers for treatment purposes. I may opt out of the Epic Care Everywhere® program by telling the registrar at my physician's office or by contacting NMCareEverywhereAssistance@nm.org.

F. I agree that the consents and permissions set forth in this Section 2 apply to all my special health information in NM's possession, including information concerning care received prior to or after the date of this form. I also understand that I may revoke the consents set forth in this Section 2 by providing written notice to NM and understand that if I revoke the consents, it will not apply to any uses and releases of my health information already made by NM before my revocation. This means that my special health information will become part of my electronic medical record and remain in that record even if I revoke my consent. The permissions I have given in Section 2 will expire one (1) year from the date that I sign this form unless I provide NM written notice of a change.
I understand that I have the right to inspect and copy any of my special health information to be used or disclosed.

3. FINANCIAL CONSENTS AND ACKNOWLEDGMENTS

A. I agree I am financially responsible for and agree to pay NM for services, supplies and use of facilities to provide my medical care and understand NM will charge me at the applicable rate for each location that I receive medical care. If I choose to have my health insurance reimburse NM for my medical care, I give permission to NM to bill any such insurer and update that information as necessary. I understand that insurance coverage varies and that my insurer may not pay for everything or may pay only part of my bill. If my insurer has an agreement with NM, then except for any applicable co-payments, coinsurance or deductibles, I will not be responsible for charges over the rate my insurer and NM have agreed upon. I understand that my insurer may deny payment for services that the insurer decides are not "medically necessary" or that are "experimental." While NM will take reasonable steps to appeal these denials, I understand that I am responsible for paying for services denied by my insurer.

My Consent to Medical Care (continued)

If I choose to have NM bill my health insurance to pay for my treatment, I assign to NM my rights to receive payment from my health insurer. If my insurance benefits are provided through an ERISA plan, I hereby assign, transfer and set forth all my rights, title and interest as a beneficiary of the ERISA plan to NM, with regard to my treatment and care. I also appoint NM 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 NM to establish my eligibility for my insurance benefits. If I claim benefits under Title XVIII of the Social Security Act (Medicare), I hereby certify that the information I provide in applying for payment of such benefits is correct, and I authorize NM to release to the Social Security Administration, its intermediaries or carriers any information needed for this or any related Medicare claim. Even though I may assign my right to receive payment from my insurer, I understand and agree that NM may still require payment directly from me.

B. As required by the Fair Patient Billing Act, I understand:

1. I may receive separate bills from NM physicians for the services provided to me.
2. All physicians may not participate in the same insurance plans and networks. Services provided by non-participating providers in an insurance plan or network are defined as "out-of-network services." I understand that I may have greater financial responsibility for out-of-network services. I understand that it is my responsibility to contact my insurance company to determine whether NM is a participating provider in my insurance plan or network.
3. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan, my employer or my insurance certificate of coverage. NM cannot guarantee that a service will be covered under my plan.

C. If I do not have health insurance or have difficulty paying my NM bill, NM provides financial assistance options, including free care, discounted care or interest-free payment plans. Information about NM's financial assistance program, qualification criteria and whether or not my physician or other providers offer financial assistance is available from NM Financial Counseling or my physician.

I have read, understand and agree to this Consent to Medical Care Agreement. I have been given the opportunity to ask questions and I have no remaining questions at this time. I understand where I can access additional information.

Time	Date	Patient Name/Signature for patients age 12 or over

Time	Date	**Signature of (circle one):** Parent Guardian Legal Representative

Time	Date	Witness/Signature

Place patient label here