Patient Name: _____

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Place Patient Label

RUSH

GENERAL AGREEMENT AND CONSENT TO MEDICAL CARE

General Agreement and Consent to Medical Care

IDN1510617

Welcome to RUSH University Medical Center / Rush Oak Park Hospital ("RUSH"). As multidisciplinary academic health care providers, we thank you for the opportunity to serve you. Before beginning with your medical care, please carefully read parts A, B, and C of this General Agreement to Medical Care ("Agreement"). Once you consent, or your legal representative consents, to the terms of this Agreement and sign page 4 of this form, you authorize, or your legal representative authorizes, RUSH to provide you with medical care, share your health information as necessary, and receive payment for the services provided. Visit RUSH.edu online for more information about RUSH.

A. Acknowledgments and General Consent to Medical Care

1. By signing this form, I consent to general diagnosis, medical care, and treatment (including anesthesia), as recommended by RUSH 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 the terms of this Agreement apply to my newborn for their diagnosis, medical care, and treatment.

2. I understand that healthcare provider(s) involved with my diagnosis, medical care, and treatment include, but are not limited to, my treating and consulting physicians, Emergency Department physicians, anesthesiologists, medical specialists, radiologists, any allied healthcare providers employed by these physicians, and other *Independent Medical Practitioners who are **not employees or agents of RUSH** but are permitted to use RUSH hospital facilities for the care and treatment of their patients. (See 3* below).

3. *Independent Medical Practitioner Services: Some medical providers on the staff of this hospital are not employees or agents of RUSH but rather are independent providers who have been granted only the privilege of using RUSH facilities for the care and treatment of their patients. They include, but are not limited to, physicians, radiologists, anesthesiologists, pathologists, surgeons, obstetricians and other specialists. My decision to seek care from an independent medical practitioner(s) at RUSH is not based on any understanding, representation, or advertisement that the independent medical practitioners treating me are employees or agents of RUSH. I understand that the independent medical practitioners who will be providing such professional services will be doing so on my behalf. I acknowledge that no guarantees have been made to me as the result of treatment or examination by an independent medical practitioner(s) at RUSH.

4. I understand that because RUSH has an academic mission to educate and train medical residents, "fellows," and nurses, they may be involved with my medical care and treatment.

5. I understand that because RUSH has a medical research mission, my physician(s) or RUSH researchers may contact me to discuss research opportunities. It is my choice whether or not to participate. I understand that RUSH research opportunities include, but are not limited to, the use and sharing of my excess body tissue or fluids intended for educational and scientific research, with or without my personal identification as authorized by law.

6. I understand that RUSH does not control or direct a physician's care of her or his patients.

7. I understand that telehealth care may be available if appropriate for my condition. I understand that telehealth, which is the remote provision of health care, may include the use of an interactive video and audio connection, live video conferencing, mobile communication devices (such as smartphones and tablet computers), and remote

patient monitoring. I understand that there are potential security and privacy risks with this technology, and technical concerns may arise (e.g., poor connection) that may necessitate onsite visits to the treating or consulting physician. I further agree to participate in telehealth care voluntarily with the understanding that there are certain technological limitations and potential risks as explained to me. I understand that if I have any further questions regarding the benefits and risks of telehealth care, I may consult with my health care provider at any time. I acknowledge that I have received no warranties or guarantees with respect to the benefits to be realized or consequences of receiving telehealth care.

8. I understand that RUSH is not responsible for the loss, theft, or destruction of my personal property. I agree to take full responsibility for my personal property and so release RUSH from any liability for its loss, theft, or destruction.

9. I agree that I will not take pictures, make video or audio recordings of my care, other patients, RUSH physicians, employees, medical staff, and students at any RUSH facility without proper authorization.

10. I agree that my contact information, including, but not limited to, telephone numbers, residential address, and email which I have provided to RUSH may be used by RUSH or those acting on its behalf to communicate with me.

B. Notice of Privacy Practices

Each time you visit a hospital or participate in health care with a physician or other health care provider(s), a record of your care is made. This record typically contains information regarding your symptoms, diagnosis, examination and test results, current and future treatment, as well as billing-related information. The Notice of Privacy Practices is available for you in **Appendix A** attached to this General Agreement and Consent to Medical Care; you may also review the notice online at the RUSH Internet website. It applies to all records regarding your care generated by RUSH, whether made or received by our personnel or given to others outside our organization for business purposes. If your personal physician is not an employee of RUSH or does not perform services on behalf of RUSH, then he or she may have different policies or notices regarding the physician's use and disclosure of medical information created in the physician's office or clinic.

C. Acknowledgements on Financial Responsibility and Authorizations

1. I acknowledge that I am financially responsible for the payment of my medical care, including, but not limited to, any services received, supplies, telehealth care, and the use of facilities at RUSH. I understand that I will be billed at the appropriate rate for the location where I receive medical care. I may decide to authorize RUSH to bill my insurer(s) and have my health insurance reimburse RUSH for my medical care. I will keep my health insurance information updated with RUSH to ensure proper billing.

2. I understand that my health insurer may not reimburse RUSH for all of my medical care received or reimburse only part of my bill. I understand that my health insurer may deny payment for what the health insurer has determined to be "experimental" or "not medically necessary." I understand that even when RUSH appeals my insurer's denial of payment, there is no guarantee of insurance coverage of payment. I understand that there is no guarantee of insurance coverage of payment and agree to pay for any medical care expenses that are denied by my insurer.

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3. I understand that if RUSH and my insurer(s) have an agreement on the rate of payment for my medical bill, I will not be financially responsible for billing charges over that rate. I understand that I am otherwise responsible for all applicable health insurance deductibles, co-payments, and co-insurance.

4. If I choose to have RUSH bill my health insurer(s) to pay for my medical care, I assign RUSH my rights to receive payment from my health insurer(s). If my 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 RUSH for the payment of my medical care. I appoint RUSH as my authorized representative to receive information on the plan coverage and to appeal any rights to payment and healthcare options. I agree to assist and provide information to RUSH to confirm my eligibility for my insurance benefits. If I am covered by Medicare (the Social Security Act, Title 18), I hereby certify that the information I provided to secure payment of such benefits is correct. I authorize RUSH to release to the Social Security Administration, its intermediaries or carriers any information necessary for all Medicare claims. Even though I may assign my right to RUSH for payment from my insurer(s), I understand and agree that RUSH may still require payment directly from me.

5. AUTHORIZATION TO DISCUSS MEDICAL INFORMATION: It may be necessary for RUMC to disclose your medical information (also known as protected health information) to physicians, nurses and other health care professionals in connection with your treatment; to insurance companies and plans in connection with obtaining payment for your treatment; and otherwise as permitted by law. Please understand that by signing this form, you authorize RUMC to release both routine and sensitive medical information, including, for example, information relating to AIDS/HIV, mental health treatment, or drug and alcohol abuse. RUMC will make reasonable effort to limit disclosure of protected health information to the minimum necessary to accomplish the intended purpose.

6. As required by the Fair Billing Act, I acknowledge my understanding of the following:
   a. For various services that I was provided at RUSH, I may receive separate bills;
   b. RUSH physicians and providers participate in limited insurance plans and networks; therefore, their services may not be covered by my insurer(s). “Out-of-network services,” or services provided by non-participating providers in an insurance plan or network, may have a greater impact on my financial responsibility for the payment of those services. I am responsible for ensuring that RUSH is a participating provider in my insurance plan or network; and
   c. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health insurer(s), my employer, or my insurance certificate of coverage. RUSH cannot guarantee that any services rendered will be covered under my health insurance plan.

7. Independent Medical Practitioner Services: RUSH bills may not include independent practitioner services and I understand that I may be billed separately for their services. I further understand these independent practitioners may not be participating providers in the same insurance plans and/or networks as RUSH.

8. I understand that if I have any questions regarding my ability to pay my hospital bill, I may call a RUSH Financial Counselor at (312) 942-5967.

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9. If I do not have health insurance or have difficulty paying my medical bill, I understand that RUSH may be able to provide financial assistance options, including interest-free payment plans, discounted care, or free care, if I am qualified. I understand that a RUSH Financial Counselor can provide more information on RUSH's financial assistance programs, qualification criteria, and whether or not my health care provider(s) offer financial assistance.

I have read and understand and voluntarily agree to this General Agreement and Consent to Medical Care. I acknowledge receipt of the Notice of Privacy Practices. I have been given the opportunity to ask questions and I have no remaining questions at this time. I understand that I may request for and receive any additional information I may need during my stay at RUSH. Finally, in case I am a minor (under age 18) or incapacitated, my legal representative is authorized to agree to this General Agreement and Consent to Medical Care and sign on my behalf:

_____ _____

Patient's/Legal Representative's Signature Date

_____ _____ AM / PM

Print Name Time

If applicable:
Legal Representative's Relationship to the Patient: _____

_____

Witness

_____

Print Name

If a certified interpreter services used:

_____ _____

Certified Interpreter's Name ID#