Northwestern Medicine®

PATIENT LABEL

CONSENT TO MEDICAL CARE AGREEMENT

Thank you for seeking care from Northwestern Medicine, the integrated academic health system of Northwestern Memorial HealthCare, including hospitals and providers ("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 providers, please go to nm.org, call our main number (312.926.2000) and ask for Physician Referral, or send an email to PhysicianReferral@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 provider(s), including treatment and services through the use of telehealth technologies, such as telephonic and interactive audio-visual communications and other virtual care (for example, My Chart communications). I understand that for services I receive using telehealth technologies I may be in a different location than the provider. 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 "providers" include, but are not limited to, physicians and other healthcare providers that are 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.

D. 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. If I do not want to receive text messages or phone calls, then I can email nmapptsvcs@nm.org and ask to be removed from the list.

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

G. I understand that NM's mission includes research to advance knowledge and medical breakthroughs. Research at NM follows a special process to ensure patient safety, welfare, and privacy of those who participate. I may speak to my providers involved with my care about research opportunities at NM. If I prefer not to be contacted about opportunities to participate in research by someone not involved in my care, I can ask that NM remove me from the contact registry by contacting the NM Office of Research at 630.933.6528. Please see NM's Notice of Privacy Practices for explanation as to how NM complies with applicable privacy laws in research activities.

H. I understand that NM's mission includes research. I understand that NM may use or share my excess tissue or body fluid for educational and research purposes in accordance with law.

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2. MY HEALTH INFORMATION

A. My health information includes diagnostic information, lab tests, medications, allergies, history and assessment, treatment plans, progress or presence in treatment, clinical notes, discharge summaries and other records pertaining to my treatment. 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 "sensitive" health information including health information as defined above 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 to and among NM providers and re-disclose outside of NM my sensitive health information for treatment, payment and NM operations, including care coordination, in the same way that HIPAA allows NM to use or disclose my other health information for these purposes and as described in the NM Notice of Privacy Practices. I understand that payment purposes includes disclosing my health information to any health plan, Medicare, Medicaid or other government program or other payer that I identify to NM.

E. If my consent is required by law, I also agree that NM may further re-disclose, as allowed by HIPAA, my sensitive 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 their treatment, payment and healthcare operations purposes. "Non-NM" providers may include Ann & Robert H. Lurie Children's Hospital of Chicago and its affiliates. Non-NM providers may also include providers participating with NM in programs allowing for the exchange of health information between providers for purposes of treating me or coordinating care, including, but not limited to, eHealth Exchange and, where my NM provider uses Epic as its electronic health record, the Epic Care Everywhere® program as described further in the NM Notice of Privacy Practices, Epic Connect, EpicCare® Link, and Epic Carequality. I may opt out of the Epic Care Everywhere® program by telling the registrar at my provider's office or by contacting NMCareEverywhereAssistance@nm.org.

F. I agree that the consents and permissions as described in this Section 2 apply to all my sensitive health information in NM's possession, including information concerning care received prior to or after the date of this form. I understand that I may withdraw my consent as described in this Section 2 by providing written notice to NM at the addresses provided in the NM Notice of Privacy Practices. If I withdraw my consent, I understand that NM will not use or disclose my sensitive information (unless otherwise allowed by law) for research recruitment and will opt me out of the Epic Care Everywhere® program and other health information programs where feasible. I also understand, however, that if I withdraw my consent, my withdrawal will not apply to any uses and releases of my health information already made by NM before I changed my consent choice or, other than described above, to any health information that has become part of my record before I changed my consent choice. I understand that I have the right to inspect and copy any of my sensitive health information to be used or disclosed.

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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.

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 or plan. 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 and grant NM limited power of attorney 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 providers for the services provided to me.
2. All providers 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 provider offer financial assistance is available from NM Financial Counseling or my provider.

I understand this consent will expire one (1) year from the date this document is signed. I acknowledge that this consent will apply to all patient encounters within NM prior to the expiration of this consent.

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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. I understand that NM cannot honor any changes that I may make to this document.

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