UI Health | UIC

Consent for Treatment and Authorization

Patient Label

Your consent and authorization for treatment

I am aware that this consent covers the care and treatment that I will receive at the University of Illinois Hospital & Health Sciences System (UI Health).
UI Health is run by the Board of Trustees of the University of Illinois. This consent will cover all services and claims processing for care at UI Health. I agree that this consent will expire when services, claims and cost sharing relating to my treatment are filed, processed and paid in full plus three (3) years from final payment received to allow for any post payment audits and claims review. I understand that if I have previously signed a consent form with greater restrictions, this consent form replaces that prior consent, unless otherwise noted.

Consenting for treatment

I consent to treatment and care for myself, or as legal guardian of the patient in question.
I am aware that the treatment and care at UI Health may come from people in its training programs. These people may include resident doctors, medical students and other health students. These students are in training and approved to give medical care. These people may interview me, examine me, or observe me. They might also perform diagnostic tests or healing procedures on me. They will do these things while being supervised by experienced clinicians.

I am aware that my care may include an HIV test.
If I want to refuse the test, I must tell my health professional. If I refuse an HIV test, I will still receive the other services that I need and are **right for me**.

I am aware that my care and treatment might include any of the following services.
- Emergency treatment or services
- Laboratory procedures
- Imaging services
- Medical or surgical treatments or procedures
- Anesthesia or hospital services

I am aware that I will be asked to sign another consent for any procedures that may have substantial risks.

I am aware that medicine and surgery are not exact sciences.
I agree that no one has made guarantees to me about the results of the services I will receive. This includes the results of any diagnosis, treatment, surgery, test or exam that has been done.

I agree to give any information asked of me to the best of my knowledge.
That includes financial, family and medical history information. I also agree that the information I have already given is true, correct and complete.

I know I can refuse to consent to any procedure or treatment.
This includes any medical or surgical procedures or other kinds of treatments.

When my care includes out-of-network providers

In keeping with the Fair Patient Billing Act:
- I am aware that I may get separate bills for services by healthcare providers who are connected to UI Health.
- Some hospital staff may not be a part of the same insurance plan and network as the hospital.
- I may have more financial burden for services given by UI Health providers who are not a part of my insurance plan.
- If I have questions about benefits and coverage, I will ask my insurance plan.

About my personal belongings

I am aware that the hospital has lockboxes I can use.
I know that I can keep my valuables there if I wish. My personal property is my obligation. This includes my eyeglasses, hearing aids, dentures, jewelry, cash, credit cards, personal electronics and all other valuables.

I hereby release UI Health from responsibility and liability for those valuables and items of personal property.

About payments and costs of my care

I agree to pay UI Health for all services and supplies provided to me.
I will pay them at the established rates. This includes any deductible, co-payment, or charges not covered by third-party payers.

I may have private health insurance, Medicare, Medicaid, or another governmental insurance program cover my treatment. If this is the case, I authorize UI Health to bill these insurers for the costs of my care and treatment.

I accept responsibility for any fees related to collecting these costs.
This includes any attorneys' fees. I certify that the information given by me for purposes of payment for treatment is, to the best of my knowledge, complete and accurate.

I am aware that many of UI Heath's outpatient offices bill for services as "provider-based" clinics.
In addition to a bill for the doctor's fee, UI Health will charge a facility fee for each visit. This is because UI Health owns the office. This means that I will receive either:

- A single bill from UI Health. It will contain fees for the doctor's services and a facility fee, or
- Two separate bills from UI Health. One will contain a fee for the doctor's services. The other will contain the facility charge.

I am aware that my insurance plan may have a different deductible and co-insurance requirement for a hospital clinic than a doctor's office.
Many insurance plans pay based on where services are given. For example, a service given in a clinic may be covered differently than a service given in a private doctor's office.

I am aware that I can check with my insurance company if I have questions about my plan's coverage.
I am aware that I can also check with my employer if I have questions about how my plan pays for provider-based clinic services.

About assignment of insurance payment benefits

I give my rights to receive payment from my health insurer(s) to UI Health and the doctors who treat me.
This is true for all my health insurer(s), whether private and governmental. I understand that I am financially obligated to pay any charges that my health insurer(s) do not cover. I understand that any payments I make to UI Health will be applied to any patient portion due from me including a current or past due balance to UI Health.

About contacting me by cell phone, text or email

I agree to receive cell phone calls and texts to my cell phone, and emails.
I will provide this contact information at registration or admission to the hospital. I agree UI Health can use these to contact me about payment and healthcare-related activities.
Healthcare activities include:

- appointment confirmations and reminders
- general health reminders, such as flu shot, immunizations
- hospital registration instructions
- pre-operative instructions
- post- discharge follow-up
- patient experience feedback
- home healthcare instructions
- servicing my account
- collecting amounts due

I agree to be contacted by UI Health.
I also agree to be contacted by any third party acting on behalf of UI Health. This includes collection agencies. I agree to be contacted by text message, pre-recorded messages, artificial voice messages, and automatic dialing system.

I am aware that I can ask to stop receiving texts and automated messages.
I can cancel these in any reasonable way. This includes canceling in person or by phone (call 866.600-2273). I can also text STOP when I receive a UI Health text message. I am aware that UI Health does not charge me for these contacts. But my phone plan's standard message and data rates may apply. These costs are my responsibility.

About using my health information

I am aware that UI Health may record my health information.
UI Health may record it in different ways. This includes electronic, photographic, digital, audio and other formats. I agree that UI Health can produce and use this recorded information for internal purposes. This includes for identification, treatment, payment and healthcare operations. UI Health can use this information for teaching and medical education. They can also use this information for reasons that are described in UI Health's *Notice of Privacy Practices*. UI Health will not release any images or audio recordings that identify me outside of UI Health, unless it's for treatment, payment or healthcare operations, or as required by state or federal law.

I am aware that the privacy of my health information is protected by federal and state laws, such as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Certain other federal and state laws protect "sensitive" health information, including information related to:

- mental health and developmental disabilities
- substance use disorder treatment, such as for alcohol and/or drugs
- genetic testing and counseling
- AIDS/HIV and related diseases
- sexually transmitted diseases
- pregnancy and birth control information
- sexual assault/abuse
- child abuse and neglect
- domestic abuse of an adult with a disability

I agree that UI Health may use and disclose my sensitive health information within UI Health for treatment, payment and healthcare operations purposes in the same ways that HIPAA and other similar laws permit UI Health to use my health information for such purposes and as listed in the UI Health *Notice of Privacy Practices*. I agree that this specific consent applies even if I am diagnosed or treated for one of the above conditions after I signed this consent for my current UI Health visit/stay.

I understand that my health information, including sensitive health information, that may be used or disclosed for the above purposes includes, but is not limited to, diagnosis, assessments, procedures, allergies, medications, test results, immunizations, visit summaries, medical and surgical histories, family and social histories, psychiatric evaluations, treatment plans, and the presence or progress in treatment.

UI Health may also disclose my health information if required by law. I am aware that the doctors, nurses and other care team members who treat me have access to my health information. They may access it to provide care during my stay/visit.

I authorize UI Health and any healthcare provider who may treat me to release any and all of my relevant health information, including sensitive health information, to certain healthcare organizations.

These may include billing and collection companies. This includes third-party payers, physicians, ambulance or paramedic services, and other healthcare personnel. Other organizations include institutions who license or accredit UI Health. For example, this may include insurance companies, health benefit plans, employers involved in approval of benefit claims, and governmental agencies.

I also agree that UI Health may re-disclose my health Information, including sensitive health information, to health professionals and providers outside of UI Health for treatment, payment, and healthcare operations purposes.

This is described in the UI Health *Notice of Privacy Practices*. I agree that UI Health may share my health information, including sensitive health information, with my past, present, and future health professionals and treating and referring providers outside of UI Health through health information exchange (HIE) programs and web-based portal systems. These programs allow secure, encrypted electronic sharing and exchange of health information, including sensitive health information, to allow providers to have the most recent available information to care for me. These programs include, but are not limited to, Epic Care Everywhere®, CarEquality, eHealth Exchange, and EpicCare® Link. If I receive services at a UI Health substance use disorder treatment program and my information is shared via an HIE, I understand that I have the right to request a list of organizations/ providers to whom my substance use information has been disclosed for the past two years.

I understand that I can revoke the consents described above by giving written notice to UI Health, but any revocation won't apply to the uses and disclosures of information made by UI Health before my revocation. I understand I have the right to inspect and copy the mental health and developmental disabilities records that may be released.

I understand that I can opt out of participating in the Epic Care Everywhere, CarEquality, and eHealth Exchange programs by completing a patient opt-out form. To request or submit an opt-out form, please contact:

- By mail: UI Hospital – HIM Department/Privacy Office, 833 South Wood Street, Suite B-52, Chicago, IL 60612, MC 772
- By fax: 312-413-8014
- By e-mail: privacyoffice@uic.edu

Please allow up to two (2) business days after receipt for processing the form. For questions, please call 312-355-5650 during business hours (Monday to Friday, 9:00 am – 5:00 pm).

I understand I may be contacted by healthcare providers or researchers at UI Health to discuss voluntary participation in clinical research projects I understand I may refuse to participate without affecting my access to future care in any way at UI Health.

I am aware that if I have enrolled in a clinical trial or research study at UI Health, EpicCare Link may be used to share my health information (including sensitive health information) with people involved in the research. This includes the clinical trial, research sponsor and other research staff who are part of the clinical trial or research study.

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Sharing my information in the UI Health Patient Directory

I am aware that UI Health may use and share specific information about me in the UI Health patient directory.
This information includes my name, the location where I am receiving care, my condition in general terms, and my religious affiliation. I further understand that this information, except for religious affiliation, will be shared with people that ask for me. This includes the media. UI Health will only provide my religious affiliation to clergy, even if they do not ask for me by name.

I am aware that if I do not want my information listed in the patient directory, I need to initial below.
_____ *I am exercising my right to keep my health information out of the UI Health patient directory. I am aware that this means florists and other visitors may not be able to find my room or contact me. These visitors may include family members.*

Patient complaints

UI Health hopes that every patient's visit goes smoothly.
If yours doesn't, it is important to share your concerns with us. We will take the appropriate steps to address them. Every patient has the right to share a complaint or concern regarding any aspect of his or her visit and expect a timely response. This includes concerns about medical care, service, conditions and billing. You can share your concerns in writing or speaking in person.

If you have comments, questions or concerns, we suggest that you or someone on your behalf takes steps.
Discuss your concerns with a member of your care team. Or speak to the manager of the clinic or unit where you are receiving care.

If you don't believe your questions or concerns have been reasonably addressed.
You may request a review. Contact the Patient & Guest Experience Office by phone at (312) 355-0101. You can also contact them by writing to the address below:

Patient & Guest Experience Office
University of Illinois Hospital & Clinics
1740 West Taylor Suite 1170
Chicago, Illinois 60612

This consent may be revoked in writing by me at any time
Revoking this consent will not change actions that have been taken while the consent was in place.

PATIENT NAME (PLEASE PRINT) _____ PATIENT SIGNATURE _____

TIME _____ DATE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, PLEASE COMPLETE

Patient named above is a minor, _____ years of age.

Patient named above is unable to sign because: _____

☐ Mother _____ Date/Time ___/___/___ ___:___ AM PM

☐ Father _____ Date/Time ___/___/___ ___:___ AM PM

☐ Legal Guardian _____ Date/Time ___/___/___ ___:___ AM PM

☐ Telephone Consent Consent Witnessed By: _____

☐ Administrative Consent Hospital Administrator (needed with Administrative Consent): _____

Attending MD (needed with Administrative Consent): _____