

CONSENT FOR CARE AND SERVICES

52545-000 (9/2020)



Please read this form carefully. This "Consent" form explains how we provide care, share your information, receive payment for the services provided, and perform certain business functions. Unless it is an emergency, you must sign this form before receiving care. We cannot accept any changes to this form. Please let us know if you have questions or concerns about the information below.

My Consent for Care and General Terms

Who We Are: In this Consent, the term "NorthShore" "we" or "us" means: NorthShore University HealthSystem (including, but not limited to, Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, NorthShore Home and Hospice Services, NorthShore Immediate Care, and any other NorthShore patient care location), certain organizations owned or controlled by NorthShore (the "Affiliates") including, NorthShore Medical Group and Swedish Covenant Health, and the physicians, nurses and other staff or employees of NorthShore and the Affiliates.

Providing Care: I give my consent for NorthShore to provide care to me/my child ("me", "my" or "I"). I understand that care means all medical services, including, but not limited to, examinations, treatment, and diagnostic procedures. Care may also include mental health evaluation and treatment. If I am pregnant, I agree that all the provisions in this Consent also apply to my unborn child/children for their care while I am receiving care from NorthShore.

I understand that this form authorizes any reasonable medical action taken for any purpose while I receive care with NorthShore, which may include HIV testing, unless I specifically opt-out of the HIV testing by informing my treating provider that I decline such testing. The diagnostic procedures and medical treatment to be provided shall be determined by my physician(s) or other appropriate practitioners, as necessary or advisable at the time treatment is performed. I understand that no guarantees have been made to me about the result of my examination or treatment.

I understand that NorthShore's mission is fostered through the training of healthcare professionals. I agree that physicians, residents, fellows, nurses, technicians and other healthcare professionals in-training may be actively involved in my care and treatment.

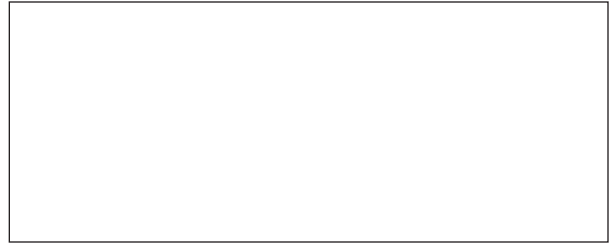
Independent Physician/Provider Services: *I acknowledge and fully understand that only those physicians/providers who are clearly identified as NorthShore employees are employees or agents of NorthShore. Non-employed physicians/providers are independent providers who are permitted to use NorthShore facilities to render medical care and treatment. These independent physicians/providers exercise their own medical judgment in treating me or otherwise providing professional services to me. I understand that I should ask my physician any questions I may have about his or her employment status and his/her participation in the same insurance plans as NorthShore. My decision to seek medical care is not based upon any understanding, representation, advertisement, media campaign, inference, presumption, or reliance that the physicians providing care and treatment to me are employees or agents of NorthShore. By my signature below, I confirm that I acknowledge and understand that NorthShore uses independent contractors or practitioners to provide various services as described herein.*

Language Assistance: If applicable, I have identified my preferred language and whether I require qualified interpreting or other language assistance services during registration. I understand that qualified interpreting and other language assistance services are available to me at no cost and, if I did not elect to have language assistance services at registration, I may request these services at any time during my visit by notifying a member of the patient care team.

Advance Directive: I acknowledge that I have the right to formulate an advance directive and to have NorthShore comply with these directives. If I have provided NorthShore with a copy of my advance directive, NorthShore will honor my expressed wishes and directives as fully and as reasonably possible, and in accordance with Illinois law. My access to care, treatment, and services, however, is not dependent upon whether or not I have an advance directive.

Photography and recordings by patients: I understand that I am not allowed to take pictures or to record care or treatment provided by NorthShore. To respect the privacy of other patients, I understand that I am also not allowed to take pictures or record other patients.

Photography and records by NorthShore: I understand that NorthShore and my individual provider(s) may need to take photographs, video and/or audio recordings to document a medical condition, help with the diagnosis and/or treatment of a condition, and/or help plan details of care. I give permission for NorthShore to take photographs, videos, digital and other images or recordings of me for treatment, education and operational purposes. I also give permission for NorthShore to use and disclose non-identifiable images externally for these purposes without additional authorization. I understand that all reproduction and all copyrights associated with these images and media are and shall remain the property of NorthShore, its successors and/or assigns.



Personal Property: I understand that NorthShore is not responsible for the loss, theft, or destruction of my personal property, including valuables that I bring with me to NorthShore. I release NorthShore from responsibility and liability for the loss, destruction or theft of any personal property that I bring with me to NorthShore.

Expiration and Revocation: Unless revoked or replaced, this form will expire when the patient reaches age 18 or is emancipated. For patients over the age of majority, this form will expire when revoked or replaced. I may revoke my permission to share my Health Information (as defined below), and this Consent, by writing to NorthShore's Health Information Management Department at: 4901 Searle Parkway, Suite 170, Skokie, IL 60076; or by e-mail to: hipaa@northshore.org. I understand that if I revoke my permission to share my Health Information, it will not apply to any actions taken by NorthShore while the Consent was effective.

Using and Sharing My Information

The Law: There is a federal law called the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This law requires NorthShore to protect the privacy and security of its patients' treatment, contact, and financial information. Taken together, this information is called your "Health Information". There are also other federal and/or state laws that require NorthShore to take additional steps to protect certain categories of Health Information, including, but not limited to, Health Information about behavioral or mental health; developmental disabilities; treatment for substance abuse (alcohol and/or drugs) disorders; genetic testing and counseling; HIV/AIDS; sexual assault/abuse; sexually transmitted illnesses; pregnancy; birth control; domestic abuse of an adult with a disability; child abuse and neglect.

Authorization and Notice of Privacy Practices ("NPP"): If my permission is required by law, by signing this form I agree that NorthShore may receive, use and disclose my Health Information as set forth in this Consent and as set forth in NorthShore's NPP. I understand that I can find more information about my rights to my Health Information, and about how NorthShore uses my Health Information, in the NPP. I acknowledge that if I requested a copy of the NPP that I have been given a copy. I further understand that the NPP is available on NorthShore's website at: www.northshore.org.

I agree that my permission applies to all of my Health Information in NorthShore's possession, including but not limited to my contact information, diagnostic test results, problem and medication list, medical history, and other clinically relevant data.

I understand that NorthShore cannot control how others that receive my Health Information will protect or use my information. I understand that others may not be required by law to protect my Health Information.

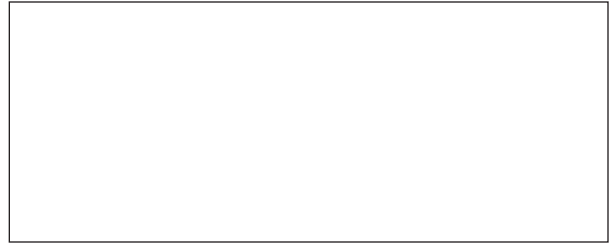
I understand that if a patient is between the ages of 12 and 18 years old, Illinois requires that the patient must also give permission by signing this form, as appropriate.

Purposes for which my Health Information may be shared: I understand that NorthShore may receive, use, and disclose my Health Information for the purposes outlined in the NPP. In particular, NorthShore may use and disclose my Health Information for the following purposes:

Immunization Tracking Purposes: I-CARE is an immunization record-sharing computer program developed by the Illinois Department of Public Health. I-CARE helps health care providers record, track and report their patients' immunizations. Participation is voluntary. If I prefer not to participate, I must notify NorthShore's Health Information Management Department in writing at: 4901 Searle Parkway, Suite 170, Skokie, IL 60076; by e-mail to: hipaa@northshore.org or by phone: 847.982.4444.

Data Sharing Program Purposes: "Other Providers" also may include my providers participating in data sharing programs such as: Epic CareEverywhere®, Epic CareEquality, EpicCare® Link, or other similar data sharing programs not listed here. These data sharing programs allow my providers to exchange my Health Information for treatment purposes, including in emergency situations. I give my permission to NorthShore to send and receive my Health Information electronically with my other providers. If I prefer not to participate, even in an emergency situation, I must notify NorthShore's Health Information Management Department in writing at: 4901 Searle Parkway, Suite 170, Skokie, IL 60076; by e-mail to: hipaa@northshore.org or by phone: 847.982.4444.

Operational Purposes: I agree that the contact information I give to NorthShore, such as telephone numbers and email addresses, may be used by NorthShore and third parties acting for NorthShore to communicate with me for operational purposes including appointment follow up, treatment reminders, and patient surveys.



Marketing Purposes: I further agree that the contact information I give to NorthShore may be used by NorthShore and third parties acting for NorthShore to communicate with me for commercial, advertising or marketing activities, including collection or billing matters. I understand and expressly consent to be contacted by auto-dialed and/or artificial or pre-recorded text messages or telephone calls or voicemails at the number I provided to NorthShore. I understand that my consent is not required as a condition of purchasing or receiving any goods or services from NorthShore. If I desire to revoke my consent, or do not want to be contacted for marketing purposes, I must notify NorthShore by calling 847.570.3187 or by email to: marketing@northshore.org.

Research Activities: I understand that NorthShore's mission includes advancing knowledge and scientific discoveries through research. Providers and/ 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 about research, I must notify the NorthShore Research Institute in writing at: 1001 University Place, Evanston, IL 60201; by e-mail to researchoptout@northshore.org; or by phone: 224.364.7100. I understand that NorthShore may use and share my excess tissue or body fluid for educational and research purposes in accordance with law. Further, I understand any rights including, but not limited to, economic, research, and/or property rights, relating to such specimen or tissues remain with NorthShore.

Financial Acknowledgments

Payment for Care: I understand that by signing this form, I agree that NorthShore will bill my health insurance for the cost of my care. In exchange for the care provided, I assign and transfer and set forth my rights, title and interest to any and all medical reimbursement under my insurance policy, subscription certificate or other health benefit coverage agreement otherwise payable to me to NorthShore.

I give my permission for NorthShore to release all medical information that may be necessary for the payment on my behalf for the health care services rendered to the patient named in this Consent.

I understand that insurance coverage varies and that my insurer may not pay for everything or may pay only part of my bill. I understand that my insurer may deny payment for services that are not covered by my plan, or that the insurer decides are not "medically necessary," "experimental," or not covered. While NorthShore may take reasonable steps to appeal these denials, I understand that I am fully responsible for payment of all charges not covered by medical insurance.

I agree that I am responsible for any expense of NorthShore in collecting the amounts guaranteed hereby, including all court costs, reasonable attorneys' fees and all other expenses. I authorize NorthShore to file a lien, or any other action permitted under Illinois law, to obtain full payment for the services provided.

Billing Providers: I understand that care and services provided at NorthShore may include the following providers: Evanston Hospital, Glenbrook Hospital, Highland Park Hospital, Skokie Hospital, Swedish Hospital, NorthShore Immediate Care, NorthShore Medical Group, NorthShore Lab Services and/or NorthShore Home and Hospice Services, all of their physicians, nurses and staff. I understand that each provider may bill me separately.

I understand that NorthShore cannot guarantee that a service will be covered under my health plan. I understand that it is my responsibility to contact my insurance company to determine whether a provider or hospital service will be covered by my insurance. I also understand that I should ask my physician any questions I may have about his/her employment status and whether he/she participates in the same insurance plans as NorthShore. I understand that if I receive "out-of-network" services, I may have greater financial responsibility to NorthShore for payment for these services.

I understand that even if a service is covered, or partially covered, by my insurance plan, I may still be responsible for part of the cost. It is my responsibility to contact my insurance company to determine the cost of the service I will be required to pay.

ERISA: If my insurance benefits are provided through an ERISA plan or other employer group health plan, and if permitted under the plan terms, I assign, transfer and set forth all my rights, title and interest as a beneficiary of the plan to NorthShore, for my care. I also appoint NorthShore 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 NorthShore to establish my eligibility for my insurance benefits.

Medicaid/Medicare: If I am seeking services to be covered under Medicare or Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for provider services to the provider(s) or organization furnishing the services or authorize them to submit a claim to Medicare or Medicaid on my behalf.

Financial Assistance: If I do not have health insurance or have difficulty paying my bill, NorthShore provides eligible patients financial assistance options, including free care, discounted care or interest-free payment plans. Information about financial assistance, qualification criteria and whether or not my physician or other providers offer financial assistance is available to me upon request.



By signing below, I confirm that I have read, understood and agreed to the contents of this form, the Consent, including the specific language related to independent physician services. I have been able to ask questions, and all of my questions have been answered to my satisfaction.

This Agreement is written in English. If this Agreement is translated into any other language, the English version shall control.

All required signatures must be provided for the form to be valid:

<div>Signature of Patient (age 18 or older) or Personal Representative</div> <div>Relationship to Patient (check one): <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Legal Representative</div>	<div></div> <div>Date</div>
<div>Signature of Minor Patient (age 12 to age 17)</div>	<div></div> <div>Date</div>
<div>Signature of Witness or Employee</div>	<div></div> <div>Date</div>
<div>Signature/Name of Interpreter (if applicable)</div>	<div></div> <div>Date</div>