Edward-Elmhurst HEALTH | Healthy Driven

EHV AGREEMENTS AND AUTHORIZATION

CONSENT TO HEALTHCARE SERVICES

- I, (the Patient signing below, or person signing below who is responsible for consenting on Patient's behalf) request and consent to all care, treatment, and other services that may be ordered, requested, directed, or provided by physicians, or their associates, assistants, or designees, and carried out by physicians or personnel at Edward Health Ventures DBA Edward Medical Group/Elmhurst Memorial Medical Group/Linden Oaks Medical Group.
- I understand that I have the right to refuse this care, treatment or other services, if refusal is allowed under the law.
- I understand that the practice of medicine is not an exact science. I understand and agree that no guarantees have been made, or can be made, as to the result of diagnosis, treatments and medications, tests or examinations provided at Edward Health Ventures.
- I consent to photographs or other recordings to be used for the purpose of treatment, quality assurance, or education. I understand I have the right to refuse such recordings. The photo from your State Issued ID or Driver's License will be used in our system EHR for your protection and to prevent identity theft.

TELEMEDICINE VISITS

- Telemedicine is the practice of medicine that involves the use of electronic communications to diagnose or treat patients located in Illinois who are in different locations from their healthcare providers ("Telemedicine"). Telemedicine also enables healthcare providers at different locations in Illinois to share individual patient medical information for the purpose of improving patient care.
- By executing this form, I, as patient or patient's legal representative, ("Patient") consent to the utilization of Telemedicine technologies in the course of my medical treatment and authorize Edward-Elmhurst Health and its employed and/or contracted providers to provide me with Telemedicine services. By signing below, I understand that Telemedicine services are not always a substitute for in-person visits and have limitations because no physical exams can be performed. I also affirm that I will be in Illinois when such Telemedicine services are requested.

PAYMENT GUARANTEE

- In consideration of the services provided by Edward Health Ventures to Patient, I agree to: i) guarantee payment of all charges that are related to the services provided to the Patient; ii) for all time assign and transfer to Edward Health Ventures all of the Patient's right, title and interest to medical reimbursement benefits that are available to pay for those charges; and iii) authorize payment of these benefits directly to Edward Health Ventures.
- I agree that Edward Health Ventures is not responsible for finding out if the Patient has any insurance or other benefits that may pay for care or services provided to the Patient, or what the extent of the Patient's benefits may be.
- I agree to be fully responsible for the payment of any and all charges if these charges are not covered by the assigned benefits.
- Edward Health Ventures provides many services to assist uninsured patients as well as patients who cannot afford the cost of care. I understand that if I have any questions about Edward Health Venture's financial assistance policy, I may ask the office supervisor during the registration process.

FOR MEDICARE PATIENTS

- I certify that any information given by me as the Patient or Patient Representative in applying for payment by Medicare is correct.
- I authorize any holder of medical or other information about Patient to release to Medicare or its agents any information needed for this or a related medical claim.
- I authorize payment of benefits to Edward Health Ventures on the Patient's behalf.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have been offered a copy of Edward's Notice of Privacy Practices. The Notice of Privacy Practices describes how the Patient's medical information may be used and disclosed by Edward Health Ventures and describes the Patient's rights with respect to this medical information.
- RELEASE OF INFORMATION FOR PAYMENT: I authorize Edward Health Ventures to release any and all relevant information about me from my records, including HIV, to any third-party payors responsible for payment of charges, including insurance companies and health benefits plans. I must sign an additional waiver form if I do not want any information regarding my visit shared with my insurance company and understand that I will then become personally responsible for payment for that visit.

Please turn to page 2 for signature

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EPIC CARE EVERYWHERE

- We participate in Epic Care Everywhere. Care Everywhere allows health care organizations that use Epic electronic health record (EHR) and other participating systems to share your medical records via secure, encrypted connections for purposes of enabling your treating providers to access your medical records when treating you. Care Everywhere allows a treating physician real-time access to his or her patient's medical history, previous diagnoses, results of diagnostic tests (e.g., labs, cardiology, and radiology), medications, allergies, progress notes and other crucial medical information without having to wait for these records to be transferred from one facility to another. We will make your Edward-Elmhurst Health medical record, excluding any records related to your mental or behavioral health treatment, available to other health care organizations through Care Everywhere. When it comes to your PHI, you have certain rights. This section explains your rights and some of our responsibilities to help you. If you do not want your medical record to be shared through Care Everywhere, please contact our Edward Elmhurst Health Information Management Department at 331-221-6990 and ask them to complete the necessary steps to remove you from the Care Everywhere Program.

I acknowledge that 24-hour notice is required to cancel any appointment, or I may be charged a $40.00 "No Show" fee.

I understand that all patient copays and outstanding balances are due at the time of visit.

No revisions or changes to this form by you will be accepted by Edward Health Ventures.

This agreement and authorization form will be signed each time I receive treatment at an Edward Elmhurst Immediate Care Location. If I am receiving treatment at a Physician Practice from Edward Health Ventures Physician this agreement and authorization form will be valid for a period of 365 days from the date of my signature below, unless revoked by me in writing sooner, or restricted to a shorter time period by applicable law.

I have read this entire form and any questions I had about this form have been answered to my satisfaction. I understand and agree to its contents.

Patient Name: ____ **DOB:** ______________
(Print)

____ __________________
Signature of Patient if 18 or over **DATE**

___________________________________ ___________________ _________________
OR Patient's Representative **Relationship** **DATE**
(Parent, Guardian or other representative if patient is a minor or unable to sign)

Scan under Treatment Consent