Memorial Health

# CONSENT FOR TREATMENT

## Where and when this consent applies

**I am aware that this consent covers the care and treatment that I will receive at Memorial Health ambulatory clinics ("Memorial"), whether in person or via telehealth.**

Memorial Health ambulatory clinics include Decatur Memorial Medical Group, Memorial Behavioral Health, Memorial Care, Memorial Home Care, Memorial Home Hospice, Memorial Home Medical Supply and Memorial Medical Group. This consent will cover all services and claims processing for care provided by these ambulatory clinics.

## Consenting for treatment

**I consent to treatment and care for myself or as legal guardian of the patient in question.**

**I am aware that my care and treatment might include any of the following services:**

- Emergency treatment or services
- Case management
- Counseling or therapy
- Laboratory tests
- Imaging services
- Medical or surgical treatments or procedures
- The taking of photographs
- Administration of pharmaceuticals
- Other routine medical treatments and diagnostic or technical procedures which, in the judgment of the Memorial provider, may be considered necessary or advisable for diagnosis, treatment, Memorial Health care operations and/or payment.

**I am aware that my care may include an HIV test.**

If I want to refuse the test, I must tell my healthcare 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 the treatment and care at Memorial may come from people in training programs.**

These people may include resident doctors, medical students and other healthcare students. They are in training and approved to give medical care. They 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 authorize the use of my medical records for these educational purposes.

**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, surgery and other treatments 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 understand that telehealth is the practice of delivering clinical health services via technology-assisted media or other electronic means between a practitioner and a patient who are located in two different locations.**

I understand that there are risks, benefits and consequences specifically associated with telehealth, including, but not limited to, disruption of transmission by technology failures. I understand that there will be no recording of any of the online sessions by either party. I understand that it may be determined that telehealth services are not appropriate and a higher level of care is required.

**I know I can refuse to consent to any procedure or treatment.**

This includes any medical or surgical procedures or other kinds of treatments.

## Patient Rights and Responsibilities

**I have read Memorial's policy on Patients Rights and Responsibilities.**

I understand that Memorial provides services to all persons without regard to race, color, sex, national origin, ancestry, disability, religion, sexual orientation or preference, marital status, parental status, veteran status, entitlement to benefits or union activities, or any other protected status under any applicable local, state or federal law.

**I am aware that 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 Memorial from responsibility and liability for those valuables and items of personal property.

## 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 Memorial.
- Some providers to whom I am referred may not be a part of the same insurance plan and network as Memorial.
- I may have more financial burden for services given by providers who are not a part of my insurance plan.
- If I have questions about benefits and coverage, I will ask my insurance plan.

## Payments and costs of my care

**I agree to pay Memorial for all services and supplies provided to me.**

I understand that I am financially responsible for any and all charges related to my treatment. As a courtesy to me, I understand that Memorial will submit claims for third-party coverage to my primary and secondary insurance carriers that I disclose to Memorial. I authorize Memorial to complete any forms which are needed in order to obtain payment from third-party payers, including Medicare and Medicaid, and all insurance programs in connection with my treatment. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for this or a related Medicare claim. I hereby authorize payment of insurance benefits to Memorial and assign all insurance benefits due under any and all medical policies covering me insofar as they are necessary to cover the costs thereof, including physician services. I hereby also assign to Memorial all rights under third-party payer policies, including, but not limited to, the right to designate a beneficiary, to add dependent eligibility, to have an individual policy continued or issued in accordance with these terms, and to all benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement payable for those services rendered by Memorial. In the event that payment is received causing overpayment for this visit, I authorize application of the overpayment to any unpaid Memorial bill for which I am responsible.

I guarantee payment in full of charges for services rendered by Memorial. Payment is due, in full, within 90 days from the date of services, unless arrangements are made with an authorized agent of Memorial. I agree to allow Memorial, or its agents, to access credit

history and my current credit score for unpaid account balances and financial assistance applications.

_____ *By initialing on this line, I certify that my injury is work-related and authorize Memorial to review, copy and release any and all medical records pertaining to the treatment.*

**I accept responsibility for any fees related to collecting these costs.**

This includes any court costs, collection fees and reasonable attorneys' fees incurred by Memorial in an attempt to collect any outstanding amounts due. I understand that these fees could be as much as 50% of the balance sent for collection, that the fees are in addition to the outstanding balance, and that the fees will be assessed and due at the time my account is referred to the third-party collector. I agree such collection charges or attorneys' fees are reasonable charges for collecting any unpaid balance. 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 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.

## Contacting me by cellphone, text or email

**I agree to receive phone calls and texts to my cellphone, as well as emails.**

I will provide my phone number and email address at registration. By providing my phone number and email address to Memorial, I understand that I am giving express consent to Memorial or its third-party contractors to contact me (including through an automatic telephone dialer) via telephone call, text message or email at the phone number(s) and/or email address(es) provided about payment and healthcare-related activities, including, but not limited to:

- Appointment confirmations and reminders
- General health reminders, such as flu shots, immunizations
- Registration instructions
- Post-hospital discharge follow-up
- Patient experience feedback
- Home healthcare instructions
- Servicing my account
- Collecting amounts due

**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 217–788–3186). I can "unsubscribe" from Memorial emails. I may also text STOP when I receive a Memorial text message. I am aware that Memorial does not charge me for these contacts, but my phone plan's standard message and data rates may apply. These costs are my responsibility.

## Using my health information

**I am aware that Memorial may record my health information. I hereby agree that I have been informed of and agree to Memorial Health's Privacy Practices.**

Memorial may record it in different ways. This includes electronic, photographic, digital, audio and other formats. I agree that Memorial can produce and use this recorded information for internal purposes, for teaching and medical education, and for other reasons that are described in the Memorial Health *Notice of Privacy Practices*, including the sharing and/or receiving of prescription information with a national prescription database utilized in electronically prescribing medications for my treatment, if applicable. I hereby acknowledge receipt of the Memorial Health *Notice of Privacy Practices* and understand its contents.

**I authorize Memorial and any healthcare provider who may treat me to release any and all of my relevant health information, including highly protected health information, to certain healthcare organizations.**

I hereby acknowledge that such release may include genetic information and hereby authorize the release of this genetic information for billing purposes.

## Complaints

**Memorial 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 take steps.**

Discuss your concerns with a member of your care team. Or speak to the manager of the clinic 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 appropriate individual using the information outlined below:

*Memorial Behavioral Health*
*Attention: Compliance Officer*
*340 W. Miller St.*
*Springfield, IL 62702*
*217–588–7538*

*Memorial Care*
*Attention: Director*
*340 W. Miller St.*
*Springfield, IL 62702*
*217–788–0006*

*Memorial Home Care*
*Attention: System Director*
*340 W. Miller St.*
*Springfield, IL 62702*
*217–788–9337*

*Memorial Home Hospice*
*Attention: Director*
*340 W. Miller St.*
*Springfield, IL 62702*
*217–876–4622*

*Memorial Home Medical Supply*
*Attention: System Director*
*340 W. Miller St.*
*Springfield, IL 62702*
*217–757–7103*

**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.

**If the patient is a minor or lacks capacity, the signature of the Power of Attorney for Healthcare, parent, guardian or closest relative is required.**

Signature _____ Date/time _____

Relationship to patient, if not patient _____

Witness to signature _____ Date/time _____