AMITA HEALTH

Thank you for seeking care from AMITA Health, an integrated healthcare system that includes hospitals, rehabilitation centers, ambulatory care centers, home health, hospice, diagnostic facilities and healthcare personnel. This form authorizes AMITA Health to provide treatment and related functions, contains other important information, and should be reviewed carefully. Except in cases of emergency, you must sign the final page of the form prior to treatment.

GENERAL CONSENTS AND ACKNOWLEDGMENTS

I authorize and voluntarily consent to all care, treatment, and other related services (including diagnostic procedures, tests, radiology, anesthesia, emergency care, the administration of fluids and medications, and other nursing, medical, and surgical treatment and care) that is considered necessary or recommended by my treating or consulting physicians (including their associates or designees) and other healthcare providers who are part of my care at AMITA Health ("Practitioners"). I understand that I have the right to consent to, or to refuse to consent to, any particular proposed medical procedure or course of treatment and that, except in emergency circumstances, no substantial medical procedure will be performed on me unless and until I have had an opportunity to discuss the procedure with the applicable Practitioner(s).

I acknowledge that no guarantees have been made, or can be made, regarding any care, treatment, or other related services that may be provided by any Practitioner, or at any AMITA Health facility.

I understand that AMITA Health participates in health care education and consent to the supervised involvement of students, residents, and fellows in my care and treatment.

I authorize AMITA Health to retain, preserve, and use for scientific or teaching purposes (or to dispose of, in AMITA Health's discretion) any specimen or tissue sample taken in the course of providing care and waive ownership rights to such specimens. If, in connection with my care or treatment, an employee of AMITA Health or any Practitioner is exposed to my blood or bodily fluids, I authorize and consent to a sample of my blood being drawn and tested for infectious diseases of any nature or description.

I authorize AMITA Health to create recordings and images of me for purposes of treatment, safety, medical research, and education, and I waive ownership rights to these images. I understand that every effort will be made to protect my identity.

I understand that, in certain circumstances, AMITA Health/my Practitioners may use telehealth services. Telehealth is the use of electronic information and communication technologies by a Practitioner to deliver services to an individual when he/she is located at a different site than the Practitioner. I understand that AMITA Health/Practitioners will determine whether my specific clinical needs are appropriate for a telehealth encounter.

PRACTITIONER EMPLOYMENT STATUS

I understand that all Practitioners who provide care, treatment, and other related services to me are INDEPENDENT PRACTITIONERS and not employees or agents of an AMITA Health entity, except for those Practitioners who clearly and explicitly identify themselves as facility employees by wearing an identification badge with the facility name. I understand that each Practitioner is solely and exclusively responsible for the exercise of his/her own independent medical judgment and is solely responsible for the care, treatment, and services that he/she orders, requests, directs, or provides. I acknowledge that the employment or agency status of Practitioners who treat me is not relevant to my selection of AMITA Health for my care, and I neither require nor is it my expectation that any Practitioner providing me with Practitioner services be an employee of AMITA Health. I also understand that I may receive, and am solely responsible for payment of, a separate bill from each of these Independent Practitioners, or groups of Practitioners, for care, treatment, or services provided. By initialing below, I acknowledge that I fully read and understood this paragraph and have had all of my questions or concerns regarding the employment status of my Practitioners satisfactorily answered by AMITA Health.

Patient/Patient Representative's Initials: _____

FINANCIAL AGREEMENT

I agree to pay for all care, treatment, and other related services provided to me by AMITA Health and Practitioners at AMITA Health facilities. I understand my financial circumstances will not affect the care I receive. I understand AMITA Health offers a variety of financial assistance programs and discounts for which I may qualify if I have difficulty paying my AMITA Health medical bills. No assignment of benefits or acceptance of partial reimbursement shall be deemed a waiver of AMITA Health's right to require full payment of all amounts associated with such care, treatment, or other related services.

ASSIGNMENT OF INSURANCE BENEFITS

I irrevocably assign and transfer to AMITA Health, and to each Practitioner, all health, medical, or other related benefits payable on my behalf under any contract of insurance, including specifically medical payment benefits under casualty insurance (e.g., automobile and homeowners insurance), or from any other source, governmental or private. I authorize AMITA Health and each Practitioner to directly apply for, and to directly receive payment of, any such benefits. If my benefits are provided under an ERISA plan, I assign, transfer and set forth all of my rights, title and interest as a beneficiary to AMITA Health/Practitioner with regard to my treatment and services. I also appoint AMITA Health/Practitioner as my authorized representative and grant a limited power of attorney to AMITA Health/Practitioner to receive plan coverage information and appeal any rights to payment and healthcare benefits. I acknowledge and understand that neither AMITA Health nor any Practitioner is responsible for determining the existence or extent of any insurance or other benefits that may be payable for care, treatment, or other service provided to me, and I agree that I am solely responsible for all charges incurred with regard to such care, treatment, and services, regardless of the existence or extent of insurance coverage (including any deductibles or co-payment amounts associated with any such insurance coverage).

NOTIFICATION CONCERNING OUT-OF-NETWORK PROVIDERS I understand that I may receive separate bills for services provided by Practitioners at AMITA Health facilities. I understand that some Practitioners who provide services to me at AMITA Health facilities may not be participating providers in the same insurance plans and networks as AMITA Health, and that I may have a greater financial responsibility for services provided by Practitioners who are not under contract with my insurance plan. I understand that if I have questions about my insurance coverage or benefit levels, I should direct them to my insurance plan.

PERSONAL POSSESSIONS

I understand that I am generally responsible for any personal property I bring with me to AMITA Health. Some AMITA Health facilities maintain a safe for storage of valuables, and I may inquire about storage of my valuables (including jewelry, documents, and cash) in such a safe. I acknowledge and agree that AMITA Health is not responsible for any loss or damage to personal property that has not been delivered to AMITA Health personnel for storage in a safe at the AMITA Health facility.

PATIENT'S RIGHTS AND RESPONSIBILITIES

I acknowledge that I have received a copy of the statement of Patient Rights and Responsibilities. I further acknowledge that a representative of the AMITA Health facility was available to explain this document to me and that I have asked any questions that I have concerning this document.

USE AND DISCLOSURE OF HEALTH INFORMATION

"My health information" includes diagnoses, test results, histories and assessments, medications, treatment plans, treatment status, procedures, clinical notes, discharge information, and other information related to my course of care, and is generally protected by the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). There are additional legal protections for "Highly Confidential Information," which is my health information relating to sensitive circumstances or sensitive diagnoses such as HIV/AIDS, behavioral or mental health, developmental disabilities, substance (alcohol and/or drugs) use disorder, genetic testing, and sexual assault/abuse. I consent to share my health information and Highly Confidential Information as follows:

I agree that AMITA Health and Practitioners may use and disclose to and among AMITA Health/my treating Practitioners, and re-disclose outside of AMITA Health, my Highly Confidential Information for treatment, payment, and healthcare operations, in the same way HIPAA allows use or disclosure of my health information for these purposes and as described in AMITA Health's Notice of Privacy Practices. I understand that payment purposes include disclosing my health information, as well as any Highly Confidential Information, to any commercial health insurer, Medicare, Medicaid, or other governmental or private payer that I identify to AMITA Health, unless I have asked that my payer not be notified and I pay for subject items and services out-of-pocket and in full, as described in AMITA Health's Notice of Privacy Practices.

I understand that AMITA Health and Practitioners may also use and disclose my health information and Highly Confidential Information without my consent or other authorization as permitted by applicable law and as described in AMITA Health's Notice of Privacy Practices. I consent to AMITA Health and my treating Practitioners requesting and receiving my health information and Highly Confidential Information from my other treating providers via health information exchanges (entities that store and/or transfer health information electronically among providers for continuity of care) for treatment, payment and healthcare operations of AMITA Health and/ or Practitioners. I agree that AMITA Health and/or Practitioners may also share my health information and Highly Confidential Information with my other treating providers outside AMITA Health via health information exchanges for treatment, payment, and healthcare operations, and that further details, including my ability to opt out of this information sharing, is more fully described in AMITA Health's Health Information Exchange Form. I understand that applicable law permits AMITA Health and Practitioners to share my health information and Highly Confidential Information through health information exchanges for certain purposes without my consent or other permission. If I want to restrict release of my health information or Highly Confidential Information through health information exchanges, I understand I need to request and complete the Health Information Exchange Form. I agree that the consents and other permissions that I gave in this "Use and Disclosure of Health Information" Section apply to all referenced information in AMITA Health's possession, including information concerning care received prior to or after the date on this form, and that I have the right to inspect and copy the information subject to the uses and disclosures described herein as detailed in AMITA Health's Notice of Privacy Practices. I understand that I may withdraw any of my consents in this Section in the future by notifying the Patient Access representatives at the AMITA Health facility(ies) where my health information is stored. I understand that my withdrawal of a consent will not apply to the extent that AMITA Health or a Practitioner has already acted and relied upon the consent. I understand that, if not withdrawn, consents in this Section are effective for fifty years from the date of signature.

By signing below, I acknowledge that I fully read and understood this section regarding Use and Disclosure of Health Information, have had all of my questions answered, have had an opportunity to request and receive a Health Information Exchange Form, and consent to the request, use, disclosure and sharing of my health information and Highly Confidential Information described in this Section.

_____

Signature of Patient or Authorized Representative

_____

Printed Name

_____

Date

Relationship to patient (check one): ___ Self Parent___ Guardian _____Other Legal Representative

_____

Signature of Witness

_____

Printed Name

_____

Date

PATIENT NOTIFICATION

I consent and agree that all mailing addresses, telephone numbers and email addresses I provide to AMITA Health may be used by AMITA Health or those acting on its behalf to communicate with me regarding matters related to AMITA Health's treatment, payment or operations (e.g., appointment reminders and registration items, insurance information, medical care, wellness programs, or patient experience). I agree that such communications may include traditional or electronic mail, phone calls (including calls to numbers that may have associated charges to me), texts and voicemail messages, and may also rely on the use of automated or pre-recorded/artificial voice messages and/ or an automatic dialing device.

MAINTAINING A SAFE ENVIRONMENT

I acknowledge that if there is a reasonable concern that I have brought with me prohibited items including alcohol, illegal drugs, or something that may be used as a weapon, AMITA Health personnel may search my room and/or belongings and confiscate and dispose of such items.

ACCEPTANCE AND SIGNATURE

I represent that I have read and understand, and am duly authorized to accept and execute, these terms and conditions, and have initialed the above paragraph regarding Practitioner employment status. Except with respect to the consents in the Uses and Disclosures of Health Information Section, this form expires one year after the date of signature. All of my questions have been satisfactorily answered. I understand AMITA Health will not be bound by any written changes I have made to these terms and conditions. I hereby accept and agree to be bound by all of the above terms and conditions, and I may request a signed copy of this document.

_____

Signature of Patient or Authorized Representative

_____

Printed Name

_____

Date

_____

Time

Relationship to patient (check one): ___ Self Parent___ Guardian _____Other Legal Representative

AMITA HEALTH®

Patient Communication Consent

PLEASE PRINT

I, _____ _____
(Name of Patient or Guardian) (Date of Birth)

hereby request AMITA Health to keep communication regarding my health information confidential by adhering to the following communication requests:

You may contact me at:

Home Phone Number: _____

Work Phone Number: _____Extension_____

Cell Phone Number: _____ ☐ You may communicate with me via text message.

Email: _____

☐ Do not contact me via phone. I will be responsible for communicating with the clinic.

If I am not available at the time of your call: ***You may leave a message and medical information on my answering machine or voicemail:***

Home: ☐ Yes ☐ No
Work: ☐ Yes ☐ No
Cell: ☐ Yes ☐ No

☐ Do not leave medical information on my answering machine or voicemail.

You may also leave a message and discuss medical information with the following person(s):

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

☐ Only leave medical information with me, the patient, or guardian.

IN CASE OF EMERGENCIES ONLY, PLEASE CONTACT:

Name: _____ Relationship: _____ Phone: (____) _____-_____

Signature: _____ Date: _____/_____/_____

AMITA HEALTH

Health Information Exchange Opt-Out/Opt-In Form

A Health Information Exchange (HIE) is a way for health care providers participating in the HIE to share health information with each other through a secure, electronic means so that health care providers have the benefit of the most current available information. AMITA Health participates in HIEs in order to facilitate and coordinate your health care.

PRIVACY AND SECURITY. Federal and state laws govern how your health information can be exchanged, viewed, or used through an HIE. AMITA Health is committed to keeping your electronic health record private and secure, and only provides, views or uses your health information consistent with those laws.

PARTICIPATION IN HIEs. Through its participation in HIEs, AMITA Health makes patient information available electronically to other HIE participants (e.g., participating hospitals, doctors, health plans and government agencies). We may also receive information about patients from other HIE participants. We expect that using HIEs will provide faster and more complete access to your health information to make more informed decisions about your care. At this time, even for patients who have consent to participation in HIE information sharing, AMITA Health does not make available through HIEs any Substance Use Disorder Information subject to 42 CFR part 2.

YOU CAN CHOOSE NOT TO PARTICIPATE (OPT-OUT). Participation is voluntary and will not affect your ability to receive medical care. If you opt-out, the HIE will block other HIE participants from electronically accessing your health information, even for emergency treatment. This means that it may take longer for your healthcare providers to get medical information they may need to treat you, or you may receive and be obligated to pay for duplicative services. Even if you do not want to participate in HIEs, state law reporting requirements will still be fulfilled through Public Health Registries. Access to your health information will be blocked within three (3) business days after AMITA Health receives this opt-out notice.

□ OPT-OUT for all health information: I DO NOT want any of my information visible within the HIEs in which AMITA Health participates.

- I understand that the applicable health information received by any AMITA Health provider WILL NOT BE VISIBLE in the HIEs in which AMITA Health participates. THIS INCLUDES EMERGENCY SITUATIONS.
- I understand that I am free to revoke this Opt-Out request at any time and can do so by completing a new AMITA Health HIE Opt-In/Opt-Out form.
- I understand that this request only applies to sharing my health information with HIEs and that a health care provider may request and receive my medical information from other providers using other methods permitted by law.

If you have previously opted out of participating in AMITA Health's HIEs and want to reverse that decision, check the box below. Your health information from the period during which you had opted-out may be available through the HIEs after you decide to opt back in.

□ OPT-IN/Cancel OPT-OUT: I WANT my information visible in the HIEs in which AMITA Health participates.

_____

Signature of Patient or Legal Representative

_____

Date Signed

_____

Signature of Parent/Guardian (If patient is under 18 years of age)

_____

Date Signed

AMITA HEALTH

Notice of Privacy Practices Acknowledgement Form

I hereby acknowledge that I have received a copy of the AMITA Health Notice of Privacy Practices.

_____
Patient or Legal Representative Signature

_____
Print Patient or Legal Representative Name

_____
Date

OFFICE USE ONLY

Acknowledgment NOT obtained because:

☐Patient or legal representative declined the Notice of Privacy Practices

☐Patient is unable to sign, and no responsible party is available prior to discharge

☐ Patient treated in emergency room and discharged before obtaining Acknowledgment

☐ Other (briefly describe) _____

AMITA HEALTH™
MEDICAL GROUP

PATIENT REGISTRATION FORM

If you are an *Immediate Care (unscheduled)* patient, please complete this section.

Do you have a primary care provider? **NO**
(Please circle) **YES** **Name of Physician:** _____ **Phone Number:** _____

Reason for visit/ Brief description: _____ **Is it work related?** _____

Patient Name: _____ _____ _____
Last Name M.I. First Name

Date of Birth: _____/_____/_____ **Sex:** □ **Male** □ **Female** **Social Security Number:**_____

Home Phone Number: _____ **Cell Phone Number:** _____

Work Number: _____ **Race\Ethnicity:** _____

Home Address: _____ Apt #: _____**Email Address:** _____

City:_____ **State:**_____ **Zip:** _____ **Marital Status:** □ **Single** □ **Married** □ **Divorced** □ **Widowed**

Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____

PRIMARY INSURANCE INFORMATION

Primary Health Insurance Company:_____ **Subscriber Name:** _____

Patient's Relationship to Insured: _____ **Subscribers Date of Birth:**_____/ _____/_____

Subscriber's ID # : _____ **Group #:** _____

SECONDARY INSURANCE INFORMATION (if applicable)

Primary Health Insurance Company:_____ **Subscriber Name:** _____

Patient's Relationship to Insured: _____ **Subscribers Date of Birth:**_____/ _____/_____

Subscriber's ID #: _____ **Group #:** _____

How did you learn of our practice?

□ **Friend/ Family** □ **Post Card/ Mailing** □ **Insurance Company** □ **Healthgrades** □ **Yellow Pages**

□ **Physician:** _____ □ **Alexian Connects** □ **Other:** _____

Preferred Pharmacy: _____ **Address:**_____

WORK RELATED INJURY: IF YOU HAD A WORK RELATED INJURY RELATED TO THIS VISIT, PLEASE COMPLETE THIS SECTION

Employer/Responsible Party: _____ **Company Contact Name:** _____

Company Phone: _____ **Employer Address:** _____

Date of Injury _____