University of Medical Center at

CONSENT FOR TREATMENT AND AUTHORIZATION

(This consent will be applicable for all clinic visits and hospital confinement relating to the treatment of my present condition and any complicating or associated conditions.)

I, THE UNDERSIGNED, a patient in the University of Medical Center hereby voluntarily, freely and knowingly agree and give my express consent to the performance of such procedures for the purpose of clinical observation, and/or the administration of whatever X-rays, injections and drugs or blood or other simple laboratory tests, as may be considered necessary or desirable, in the observation, diagnosis and treatment of my case by the physician in attendance and/or the staff of the University of Hospital. I understand that I will be asked to give separate consent for any contemplated procedure believed to involve any substantial risk.

I am aware that the practice of medicine and surgery is not an exact science and further state that no guarantee has been or can be made as to the results of the treatments or examinations in the hospital or clinics.

I declare that I have provided or will provide financial, family and medical history information requested to the best of my knowledge, and believe that such information already given is true, correct and complete.

I understand and have been told that the hospital maintains a safe for the safekeeping of money and valuables and that the hospital will not be liable for the loss of or damage to any of my personal property at any time I am hospitalized unless deposited with the hospital.

I understand that my admission to the University of Medical Center shall include my participation in its clinical training programs and hereby voluntarily consent to said participation. This consent implies that at various times I might be interviewed, examined, observed, or have diagnostic or therapeutic procedures performed on me by resident physicians, medical students, or other authorized students of the health professions. Such participation shall be appropriate to their level of training and under adequate supervision when needed.

I authorize University of Medical Center officials to release records and information relative to my care at said Hospital to doctors and/or institutions which I have named or shall name as referring me to said Hospital and/or who will be expected to assume responsibility in my continuing care.

Patient/Representative Initials _____

ADVANCE DIRECTIVES

Information regarding advance directives has been provided and the following has been executed:

Living Will _____Yes _____No

Durable Power of Attorney _____Yes _____No

Copy available _____Yes _____No

Additional Information requested _____Yes _____No

If yes, referral to social work/chaplian _____Yes

Patient/Representative Initials _____

AUTHORIZATION TO PAY INSURANCE BENEFITS

1. I hereby assign and instruct my insurance company(ies) to pay the University of Illinois Medical Center and the treating physician(s) the accrued benefits for any inpatient or outpatient hospital services rendered or to be rendered by the University of Illinois Medical Center twelve (12) months from either the date below or from the date of discharge from the hospital confinement.

2. If it becomes necessary for the University of and/or University physicians to institute legal proceedings to collect delinquent amounts due, they shall be entitled to recover their reasonable costs of collection including attorneys' fees in addition to the delinquent amounts due on the account.

3. I agree to pay the established rates of University of Medical Center and its physician for all services, facilities and supplies rendered.

Patient/Representative Initials _____

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University of Medical Center at

CONSENT FOR TREATMENT AND AUTHORIZATION

AUTHORIZATION FOR DISCLOSURE OF INFORMATION FOR HOSPITAL PAYMENT

The undersigned hereby authorize the University of Medical Center to release to employer groups, insurance companies, government agencies, or other third-party payers and their representatives or whomever we have good cause to believe is legally responsible for all or any part of Hospital charges and/or professional fees, information concerning medical care, advice, treatment or supplies or other information including medical records that may be necessary for the purpose of determining eligibility and available benefits and obtaining payments on my behalf for the health care services provided to me. This authorization may be revoked in writing at any time except to the extent that actions have been taken in reliance thereon.

If relevant, I authorize release of medical records/information concerning drug or alcohol abuse or dependency; psychiatric or psychological information; diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS) or tests for antibodies to the AIDS virus (HIV).

This authorization shall be valid only for the period of time necessary to actually process claims for payment for these services. I understand that I will be financially responsible for the charges incurred for my treatment if revocation or refusal to authorize this disclosure of my medical records/information results in a payment denial of my insurance claim.

Redisclosure of this information by its recipients is prohibited except when implicit in the purposes of this disclosure.

This authorization expires on _____ (calendar date), unless I revoke it.

I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the Health Information Management Department of University of Medical Center. I understand that if the authorization is for the purpose of third party payment to University of Medical Center, that diagnostic and therapeutic information as may be necessary to process benefits will be disclosed to my insurance agency and/or the insurance company's review agency, and that refusal to authorize information for this purpose will result in the assignment of financial responsibility to me for these services. No other adverse consequences to me will result if I refuse to sign this authorization. I agree to release and hold harmless University of Medical Center, its directors, officers, employees, successors, agents, assigns, and any and all members of its medical staff, from and against all liability, damages, claims, or suit, including reasonable attorneys' fees, in connection with the disclosure of records/information as authorized herein.

Patient/Representative Initials _____

MEDICARE RECIPIENTS ONLY

I acknowledge receipt of the message from the University of Medical Center regarding my rights as a Medicare patient. My signature does not waive any of my rights to request a review or make me liable for any payment.

Patient/Representative Initials _____

NOTICE OF PRIVACY PRACTICES

_____ I have received the Notice of Privacy Practices. _____ I have been offered the Notice of Privacy Practices and decline to accept because

_____

_____

Patient/Representative Initials _____ _____

I, THE UNDERSIGNED, certify that this form has been fully explained to me and I understand its contents and an opportunity was provided to strike out any paragraphs I did not wish included. I have been given the opportunity to ask any questions I may have concerning my treatment or the statement contained on this form.

Witness _____ Signature _____ Date _____
(Print Name)

Signature of Patient _____ Date _____

If patient is unable to sign due to legal, mental, physical incapacity or is a minor (under 18), state reason:

_____

_____

Witness _____ Representative of Patient _____

Date _____ Relationship _____