Wheaton Franciscan Healthcare

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Inpatient and Outpatient Consent for Treatment & Financial Agreement

❒ Covenant Medical Center ❒ Sartori Memorial Hospital ❒ Mercy Hospital ❒ Covenant Clinic

Patient Name: _____ Date of Birth: _____ Date of Service: _____

A. Consent to Treat

- I am coming for care or testing. I agree to have my doctor, other doctors, assistants, and other staff take care of me.
- I understand my doctor may recommend additional lab tests, x-rays, procedures, operations, medicines and/or monitoring.
- I know I might need to sign a consent form if I need an operation or special test.
- If tissue or parts are taken off when I am in the hospital the hospital can get rid of it. The hospital can keep and use the tissue or parts for teaching unless I disagree.

B. General Information

- I know that there are risks for all care. No one has guaranteed my care.
- Not all doctors at each site work for the Facility. The Facility is not responsible for the care of doctors they do not employ.
- I know that I need to follow directions. I know I need to make any follow-up appointments.
- I know that there may be health care students on the units where I might be. I know that they may take care of me. I know there may be others present during my care.
- I agree to have my medical record and other health care information disclosed following all the state and Federal laws and the privacy notice I received.
- I agree that I can request information from my medical record and look at my medical record during business hours. I know that I can use this information for my own purposes. I can get a copy of my medical record, if I pay for the copies.
- I agree that the hospital/clinic (including billing services, collection agencies and attorneys) may:
    - Call me on my cell phone and/or home phone and leave a message.
    - Text me, e-mail me or use other electronic ways of contacting me.
    - Use pre-recorded messages and automatic dialing services.

C. Wheaton Home Health, Hospice, Medical Equipment and Nursing Home Care: (Hospital Only)

- I know I may need to have care or equipment to help me when I go home.
- I know that I may pick my own provider or supplier for what I might need when I go home.
- I am aware that the Facility will suggest Wheaton Franciscan Healthcare providers and suppliers.
- I know I may pick any other provider or supplier for my home health, hospice, medical equipment, nursing home or other service.
- I will be given a list of other providers and suppliers. If I need another copy I know that I may ask for one at any time.

D. Valuables: (Hospital Only)

- I know I should not keep items (money/jewelry, important papers) at the Facility. I will send them home if I can.
- I know the Facility has a place where my items may be kept by Security.
- I keep my items at my own risk. If I keep my items I know that it is not the Facility's fault if my items are lost or broken.

E. Assignment and Agreement to Pay

- I know that I must pay for the care I get. I agree to pay for this care.
- I agree to have the Facility, doctors and others receive payment for the care I get. The payments may come from a state insurance plan (Medicare, Medicaid or other) insurance, managed care or other third party payer.
- If the payer denies payment, I will let the Facility appeal the denial for me. I agree to let the Facility ask for an independent or external review if there is one with my insurance or by law.
- I know that I must pay for anything my insurance does not cover.
- I know that not all insurance companies pay the usual fees. If that happens, when the law allows, I will have to pay.
- If I am sent to collections, I know I will have to pay for the cost of the collection and/or reasonable lawyer fees from the collection.
- I know that my health information will be released to my insurance company or others for billing including payment for disability. There may be re-disclosure of information gotten from others.
- I know that I may get separate bills from doctors. This may include radiology, anesthesia, pathology, emergency room doctors and other doctors that do not work for the Facility. These doctors may or may not be in all insurance plans.

F. Photographing

- I know that the Facility may take pictures or video of me for my care or safety.
- If I have a baby, I agree for my baby to have pictures taken for security and/or personal use in the hospital where delivery occurred.

G. Privacy Notice and Patient Rights

- I confirm that I got or was offered a copy of the Notice of Privacy Practices. I know I can get more information about uses of my medical record from that notice.
- I confirm that I got or was offered a copy of the Patient Rights and Responsibilities.
- I confirm that I got or was offered a summary of the Community Care Program, the organization's financial assistance program.
- I agree to let the Facility release information to other health care providers and school health offices through the Immunization Registry in the State of that Organization.

H. Document Changes

- I know that if I make any changes to this form prior to services performed it may keep me from getting this care and services.

_____	_____	_____	_____
Signature of Patient/Authorized Representative	Relationship of Authorized Representative	Date	Time

(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement or parental rights of the child.)

_____
Interpreter Name/Affiliation or Interpreter Name/Number if Telephonic/Video

If unable to sign document, state reason: _____

TOP OF LABEL
PATIENT LABEL MUST BE PLACED HERE
LABEL CANNOT BE IN ANY OTHER LOCATION OR POSITION
BOTTOM OF LABEL

Original – Chart • Copy – Patient