Blessing Health System
Consent to Treat and Authorizations

Blessing Convenient Care | Blessing Hospital | Blessing Physician Services | Blessing Walk-In Clinic | Illini Community Hospital

1. CONSENT FOR TREATMENT. I consent to medical care, including any examination, blood tests, laboratory tests, radiology and diagnostic procedures, medications, treatment, and other services considered necessary by my provider. I understand such healthcare services may be provided through interactive videoconferencing (telemedicine) equipment. No guarantees have been made to me about the testing/examination/treatment. I know I have the right to agree to or refuse any medical care. I agree to be tested for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), hepatitis, and/or other blood borne agents if a health care provider or first responder (police, firefighter, paramedic, etc.) is exposed to my blood or other bodily fluids. I understand this testing is allowed by Illinois law. If I am tested, I will not be billed for it. I agree to the disposal of any specimens or tissue taken from my body during my treatment.

2. INDEPENDENT/OTHER PRACTITIONERS/PROVIDERS. I understand physicians and health care providers who are not employees of Facility are **Independent Contractors.** They are not agents of Facility. Examples include:

Radiologists…………………… services may be provided by Clinical Radiologists, S.C.,
Pathologists…………………… services may be provided by West Central Pathology Specialists, S.C.,
Anesthesiologists……………… services may be provided by Quincy Anesthesia Associates, P.C,
Other Physicians/Providers….. services may be provided by Blessing Physician Services, Quincy Medical Group, or other independent physician/physician groups

I understand these independent providers use their own medical judgment for which this Facility is not responsible. I realize the independent providers will bill me **separately** from any Facility related charges. I understand some providers may not participate in the same insurance plans/networks as Facility, so I may have a greater financial responsibility for these independent services. I am aware residents, students, clinical observers, and/or medical device representatives may be present and may observe or participate in my care, within their scope of practice, unless I request otherwise.

3. PATIENT RIGHTS AND RESPONSIBILITIES, ADVANCE DIRECTIVES, AND IMPORTANT INFORMATION. Prior to treatment, I received or was offered information about Patient Rights and Responsibilities, Advance Directives, Complaint and Grievance process, and if an inpatient, Important Information from Medicare/Ombudsman information.

4. CONSENT TO OBTAIN AND TRANSFER PERSONAL INFORMATION. I authorize Facility to photocopy my driver's license, official identification card, insurance identification card and/or any other form of government-issued identification document in a way consistent with applicable law, and to record, transfer, scan and keep such information for identification purposes and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable state and federal law.

5. RELEASE OF RESPONSIBILITY FOR PERSONAL BELONGINGS. I understand that I am responsible for all my belongings/personal property I bring to Facility. I agree Facility is not liable for the loss, theft or damage of my personal property, including money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, purses, checks, documents, luggage or any other items.

6. COMMUNICATION BOARD. I understand that the Facility may use a communication board as a means of communicating with patients. If utilized, I realize this board is visibly displayed in patient rooms and may contain personal information such as my name, name of my provider(s), my medications, tests/procedures, my goals and healthcare needs, discharge education, among other information. If I do not want this information shown, I am to inform Facility staff.

7. PAYMENT AGREEMENT AND ASSIGNMENT OF BENEFITS. Unless prohibited by an agreement between my payer source and Facility or by state or federal law, I promise to pay all amounts due to Facility and Independent Contractors, including co-payments, deductibles or other charges, for medical services I received that are not covered or paid by insurance or other third party payers. I understand that the Independent Practitioners, such as radiologists, pathologists, anesthesiologists, independent providers, etc., will bill **separately** from Facility. I will use any money I receive from my insurance company to pay for the services received. I authorize Facility as my authorized representative to file any claims for payment, secure information and documents regarding my benefits, and assign all my rights and benefits to Facility and Independent Practitioners

patient information label

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as appropriate. I also agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest if Facility has to seek collection action due to my failure to pay. If I am a Medicare beneficiary, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I understand that Facility is not liable for failure to meet any pre-certification required by my insurance carrier. I agree to pay for all services if pre-certification is denied by my insurer. It is my responsibility to notify Facility of any changes in payer source.

8. PHOTOGRAPHING/VIDEOTAPING. I understand that photographing and/or videotaping of my treatment may occur for diagnosis, treatment, identification and medical purposes and will become part of my medical record. I also consent to the photographing and/or videotaping of my care for internal organizational and educational purposes if my identity is not revealed by the pictures or words accompanying them, unless I give further written consent.

9. DIRECTORY. As an inpatient or outpatient in the hospital setting, I understand I am automatically included in the patient Directory unless I have checked below to opt out of the Directory. The Directory is a listing of information that would include my name, location at the Facility, general condition and religious affiliation.

__________ I am opting out of the facility directory. (Check mark)

__________ Patient Access notified that patient is opting out of our directory. (Staff initials)

10. RELEASE OF INFORMATION. The Facility and treating provider(s) will release my confidential medical, mental health and personal information as necessary for payment, treatment, or business operations as described in the NPP. This includes to my primary care or referring physician, healthcare providers involved in my care, home health agencies, nursing homes, pharmacies, insurance companies/health coverage plans, workers compensation carrier, collection agencies, credit bureaus, their designees and to other parties as allowed by law and/or who are involved in collection of my bill. I understand if I have a communicable disease, such as HIV, tuberculosis, viral meningitis, etc., certain protected health information may be required to be released to such organizations as the Centers for Disease Control and Prevention or public health department.
I expressly consent to the release of psychotherapy notes as part of this health record for the purpose of payment, if required to support medical necessity of services. I understand I have the right to inspect and copy the information disclosed and if I refuse or withdraw this consent, the psychotherapy notes will not be disclosed resulting in potential consequences, including, but not limited to, nonpayment of my healthcare expenses by my insurance carrier or provider or denial of eligibility or coverage by my insurance carrier. Unless otherwise needed, this consent shall expire five years from the date of the consent.

11. CONTACT BY TELEPHONE/EMAIL/TEXT. I UNDERSTAND THAT I AM NOT REQUIRED TO PROVIDE THE FOLLOWING CONSENT IN ORDER TO RECEIVE TREATMENT OR OTHER HEALTH-CARE SERVICES.
I hereby authorize each Blessing Health System entity, including Blessing Convenient Care, Blessing Hospital, Blessing Physician Services, Blessing Walk-In Clinic and Illini Community Hospital ("Collectively the "Blessing Health System Entities" and each a Blessing Health System Entity") to use my demographic information, including my e-mail address, wired telephone number (land-line) and wireless telephone number (cellphone) to contact me by e-mail, telephone call or text message, including through the use of prerecorded or artificial voice messages or automated dialing devices used to make calls or send text messages. I understand that I may be charged by my internet or telephone service provider for e-mails, calls, data, or text messages received from BHS. I understand that Blessing may use this technology for HIPAA exempt purposes, for any purpose related to my healthcare, and other financial reasons related to the BHS. I understand that this authorization will not expire, but that I may revoke this authorization and "Opt-Out" and revoke this consent at any time by expressing my revocation in writing or orally to BHS, or as may otherwise be provided for in any message received from BHS. I understand that by signing this Consent form, I am opting into receiving communication as set forth herein, unless I indicate below that I elect to "Opt-Out".

__________ Opt Out

I have read this form, or had it read to me, and by signing below, I understand and agree to its contents. I give consent, authorize release, and assign benefits to Facility.

______________________________   ______ / ______ / ______

Printed Patient Name   Patient Date of Birth

______________________________   ______ / ______ / ______ : ______

Patient or Legal Representative Signature   Date   Time

______________________________   ______________________________

Print Name and Relationship of Legal Representative   Witness/Staff Signature

______________________________   ______________________________

2nd Witness Signature (if applicable/telephone consent)

______________________________   ______________________________

Print Name of Interpreter, if applicable   Signature of Interpreter

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