Prairie Cardiovascular
The Doctors of Prairie

CONSENT FOR TREATMENT

Patient Name_____ _____ _____
(Last) (First) (Middle) Social Security # Date of Birth

I. MEDICAL CARE REQUEST AND AUTHORIZATION

I understand that I may have a condition which requires medical care. I am requesting and authorizing medical care by Prairie Cardiovascular Consultants, Ltd. ("Prairie"), any of the physicians associated with Prairie and other health professionals who are associated either with Prairie or the facility at which the medical care is rendered who Prairie considers reasonably necessary for my care. I agree to their participation in my care.

I am aware that medicine is not an exact science and I acknowledge that no guarantee has been made to me concerning the results of my medical care.

I understand that unforeseen conditions may arise during the rendering of my medical care and I hereby authorize Prairie and its designees to perform any other procedures they deem appropriate in the exercise of their professional judgment to address such conditions.

I recognize that I may, at any time, be a participant in and make decisions regarding my health care, including the right to accept or refuse medical or surgical treatment, the right to formulate advance directives and to provide any such directives for my physicians and health care providers to be aware of and rely on.

I understand that I may revoke this request and authorization for medical care at any time by written notice to Prairie.

I understand that Prairie Cardiovascular Consultants, Ltd. is a personal service corporation and that Residents, Fellows, and medical students may assist in providing my care and that my medical records may be used for purposes of education and patient care by these individuals. I acknowledge and consent to designated observers being present, unless I have requested otherwise.

II. RELEASE OF MEDICAL INFORMATION CONSENT

I consent to the development, use and disclosure of medical information about me as noted in the next paragraph.

Prairie and any person or entity designated by it may develop, use and disclose medical information about me (i) for my treatment and to other physicians, health professionals or entities who may be involved in my care; (ii) to obtain payment for treatment by billing and performing any other functions necessary to obtain reimbursement for care delivered to me, including collections of such payments from me by collection agencies or attorneys; and (iii) to support Prairie's health care operations such as analyzing, monitoring and comparing patient data to improve treatment methods and for corporate compliance functions. In addition, Prairie may use or disclose medical information about me for research studies, funeral arrangements, organ and tissue donation, workers' compensation, emergencies and all uses and disclosures that are permitted or required by the laws of the State of Illinois or federal laws without my consent.

As a service to our patients, Prairie provides a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

This consent permits disclosure of information and reports in my file; HIV/AIDS, Mental Health, Drug/Alcohol Abuse, STD's, Developmental Disabilities and Genetic Testing Results, if any.

III. HEALTH INFORMATION EXCHANGE (HIE)

I understand my medical records will be exchanged among my health care providers through a Health Information Exchange (HIE). I authorize Prairie to share my information with the HIE, including sensitive information, for all individuals and entities who are authorized to access such information for purposes related to my treatment. Sensitive information includes: HIV/AIDS, mental health records, drug and alcohol treatment, genetic test results and sexual transmitted diseases.

I understand I may request to Opt-Out of HIE and continue to receive care. If I have a positive diagnosis of HIV, I understand I have the opportunity to request my information not be provided to the HIE by means of Opt- Out. If I Opt-Out, I understand my providers will not have the most up to date information about my care even in cases of medical emergency. I understand Opt-Out selection will remain in effect until I change it in writing. I understand any information disclosed before I submit this Opt-Out cannot be taken back and will remain in the HIE.

I understand if I would like to Opt-Out I need to make the request in writing. I may do so with the Registration Department, Compliance Department or the Privacy Officer.

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IV. **CONSENT TO TELEPHONE CALLS (including WIRELESS), EMAILS, and TEXTS**

If at any time I provide a telephone number through which I may be contacted, I consent to receive calls (including autodialed calls and pre-recorded messages), emails and text messages at that number from the facility, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, regarding the services rendered, or my related financial obligations.

I understand I may receive calls, email and text message communication regarding services or activities conducted on behalf of the facility. I understand and acknowledge communications transmitted via email and text message are unencrypted and are inherently unsecure, and there is no assurance of confidentiality of information communicated in this manner.

V. **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

HIPAA (Health Insurance Portability and Accountability Act) is a federally mandated law. It provides guidelines to health care providers about the privacy of my medical information and requires Prairie to inform me of its privacy policies.

I acknowledge that I have received a copy of Prairie's Notice of Privacy Practices. It describes how my medical information may be used within Prairie, how it can be disclosed outside of Prairie, how I may access my medical information and my rights with regard to my medical information. Prairie reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may request a copy of a current Notice of Privacy Practices at any time.

VI. **FINANCIAL AGREEMENT**

I understand that I am personally responsible for charges incurred for medical care rendered by Prairie. I understand that Medicare, insurance companies, my employer and other payers may have restrictions on reimbursement for medical care rendered by Prairie. These restrictions may include pre-certification, use of designated facilities, frequency of tests performed, non-covered services, deductibles, co-payments and other requirements. I understand that it is my responsibility to comply with such restrictions and that I will be personally responsible for any charges not reimbursed by other payers.

I certify that all information given by me in applying for payment by Medicare, if applicable, is correct. I understand it is mandatory to notify Prairie of any other party who may be responsible for reimbursement of my medical care. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I certify that all information given by me to bill Medicare, insurance companies, my employer and other payers is correct and complete. I understand that payers may have time limits for filing claims and providing incorrect and/or incomplete information may result in denial of reimbursement for which I will be personally responsible.

I acknowledge that should it be necessary for Prairie to refer my account to external sources for collection, I will pay a twenty-seven percent collection fee, attorney's fees and court costs that are incurred by Prairie. I acknowledge these fees are reasonable and in addition to my balances due Prairie. I agree that any credit balances resulting from payments by insurance companies, employers, myself and others may be applied against any other balances due by me or family members.

I authorize all payments for medical care rendered to me by Prairie to be assigned, transferred and paid directly to Prairie. I will remit to Prairie immediately the full amount of any payments that may be received by me, a family member or custodian from Medicare, an insurance company, my employer or any payer for medical care rendered to me by Prairie.

I hereby release Prairie from any and all legal responsibilities or liabilities relating to my financial responsibilities.

I acknowledge that I understand all of the above and agree to abide by the terms of this document.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Printed Name of Patient or Guardian Relationship to Patient