

Annual Consent for Medical Care and Services

GENERAL CONSENTS AND ACKNOWLEDGEMENTS

A. Consent for Diagnosis, Care, and Treatment: I consent to the diagnosis, medical care and treatment that I have agreed to receive and is considered necessary or recommended by the Rosalind Franklin University Health Clinic's (RFUHC) provider(s), including treatment and services may be in-person, as well as through telehealth technologies such as telephonic, interactive audio-visual communications, and other virtual care (For example through use of the Athena Patient Portal). I understand that for services I receive using telehealth technologies may be in a different location than the provider. I understand that no guarantees have been made to me about the result of my examination or treatment.

B. Acknowledgement of Educational and Research Missions: RFUHC and their affiliates share a common mission in advancing knowledge and discoveries through research and education with Rosalind Franklin University of Medicine and Science (RFUMS). I understand that my care will be provided within a teaching environment and the Physicians, Nurses, residents, fellows, and other health care professionals in training may be involved in my care and treatment. I also understand that my health information may be used within the RFUHC and its affiliates and released in accordance with the law and the RFUHC notice of Privacy Practices. I understand that my provider(s) may discuss various research opportunities that may be of interest for me and that I have the option of participating but may decline at any time.

C. Personal Property: I understand that the RFUHC and its affiliates will not be responsible for the loss, theft, or destruction of any personal property that I bring with me to RFUHC's. I release RFUHC from responsibility and liability for any personal property.

D. Photography and Recordings: I understand that I am not allowed to take pictures or use video or audio recordings of care, other patients, RFU Employees, providers, or students while within RFU facilities.

E. Language Assistance: A wide range of communication options are available based on the patient's individual needs. I understand that RFUHC utilizes qualified interpreter services and other language assistance services at no cost to me. I may request these services at any time during my visit by notifying a member of the patient care team, including my preferred language.

F. In Loco Parentis and Consent for Minors: RFUHC recognizes there may be instances when a parent/guardian is unable to accompany a minor patient to the clinic. Under Illinois law, a minor is a person who has not attained the age of 18 years and a minor cannot consent to medical treatment. A parent/guardian or person in loco parentis must consent to the treatment of a minor. The term "in loco parentis" might include an aunt or uncle or some other adult who does not have legal guardianship but who otherwise stands in the shoes of a parent. RFUHC requires the parent/guardian or loco parentis of the minor patient accompany the patient at minimum annually to provide written consent as a loco parentis designee to consent to medical consent on behalf of the minor.

HEALTH INFORMATION

A. My health information may include diagnostic information, lab tests, medications, allergies, history and assessment, treatment plans, presence or absence in treatment, clinical notes, discharge summaries and other records pertaining to my treatment. I agree that RFUHC can create recordings and images containing my health information for treatment, education and RFUHC operations as described in the RFUHC notice of Privacy Practices.

B. I understand that RFUHC and the Health System workforce adheres to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This law requires that Rosalind Franklin protect the privacy and security of its patients' treatment, contact, and financial information. Collectively, this information is referred to as your Health Information. In addition to HIPAA, there are other Federal and State laws which protect "Sensitive" health information, including health information as it relates to HIV/AIDS, behavioral or mental health, developmental disabilities, treatment for substance use disorders (alcohol and other illicit drugs), genetic

testing and counseling, sexual assault/abuse, domestic abuse of an adult with a disability, child abuse and neglect, and if as a minor, sexually transmitted illnesses, pregnancy, and birth control.

C. Treatment and Continuity of Care. As applicable and when my consent is required by law, I consent to Rosalind Franklin and its affiliates' contacting or sharing my health information with other healthcare providers to obtain information regarding my prior and current health conditions for treatment within RFUHC or as necessary for treatment, continuity of care, mandated reporting as required by law, for payment and health care operational purposes. I understand that payment purposes include disclosure of my health information to any health plan, Medicare, Medicaid, or other government program or other payer that I identify to RFUHC.

FINANCIAL CONSENTS AND ACKNOWLEDGEMENTS

A. Responsibility of Payment: I agree that I am financially responsible to and agree to pay RFUHC for services, supplies, and use of facilities which are utilized to provide my medical or behavioral health care. If I use health insurance (such as private insurance, Medicare, Medicaid, or other governmental or additional insurance plans), I authorize RFUHC to bill such insurer for all services rendered. I understand my insurance coverage may require that a portion of these charges will remain my personal responsibility such as assigned deductibles, co-payments, and charges not covered by my health insurance. I understand that my health insurance may deny payment for services for a variety of reasons. While RFUHC will take reasonable steps to appeal these denials, I understand that I am responsible for paying for services denied by my insurer. If I claim benefits under Title XVII of the Social Security Act (Medicare), I hereby certify that the information I provide in applying for payment of such benefits is accurate.

B. As required by the Fair Patient Billing Act. I understand:

- I may receive separate bills from RFUHC providers for the services provide to me.
- RFUHC providers may not participate in the same insurance plans and networks. Services provided by non-participating providers in an insurance plan or network are defined as "out-of-network services". I understand I may have a greater financial responsibility for out-of-network services. I understand that it is my responsibility to contact my insurance company to determine whether RFUHC is a participating provider within my insurance plan or network.
- Any questions I have regarding my Health Insurance Coverage or benefit levels should be directed to my health plan, my employer or insurance certificate of coverage. RFUHC cannot guarantee that a service will be covered by my insurance plan.
- If I do not have health insurance or have difficulty paying my bill, RFUHC provides financial assistance options, including free care, discounted care or interest-free payments. For additional information, please contact a RFUHC financial counselors at (847) 578-8815.

MEDICAL RECORDS TO BE RELEASED

I have read, understand and agree to the statements in this Consent for Medical Care and Services agreement. I understand this consent will expire one (1) year from the date the document is signed.

Patients 12-17 years of age must sign for mental health and developmental disability, substance abuse/alcohol treatment, AIDS or HIV testing/results, sexually transmitted infections, sexual assault, pregnancy and/or birth control counseling and information.

Date	Time	Patient Name/Signature for patients 12 years of age or older
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Date	Time	Signature of (Circle one): <i>Parent</i>	<i>Legal Guardian</i>	<i>Legal representative</i>
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Date	Time	Witness (Required for Mental Health/Developmental Disabilities records in IL)
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Information Communication Authorization