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Consent for Care and Services
Ann & Robert H. Lurie Children's Hospital of Chicago

Please read this form carefully. This "Consent" form explains how we provide care, share your information, receive payment for the services provided, and do business functions. Unless it is an emergency, you must sign this form before receiving care. We cannot accept any changes to this form. Please let us know if you have questions or concerns about the information below, or if you want a copy to take with you.

I. My Consent for Care and General Terms

- A. **Who We Are:** In this Consent, the term "Lurie Children's" means Ann & Robert H. Lurie Children's Hospital of Chicago in any of its locations. "Lurie Children's" also includes Pediatric Faculty Foundation, Inc., Children's Surgical Foundation, Inc., Pediatric Anesthesia Associates, Ltd., Lurie Children's Medical Group, LLC, Lurie Children's Primary Care, LLC, Almost Home Kids and all of their physicians, nurses and other staff. "Lurie Children's" also includes the Lurie Children's Health Partners Clinically Integrated Network, LLC, and the Lurie Children's Health Partners Care Coordination, LLC.
- B. **Providing Care:**
- i. I give my consent for Lurie Children's to provide care to me/my child ("me", "my" or "I"). Care includes medical and/or dental examinations, treatment, and diagnostic procedures. Care may also include the use of anesthesia or administration of blood, if the medical or dental staff decide it is necessary in their professional judgment. Care may also include mental health evaluation and treatment.
 - ii. I understand that this form authorizes any reasonable medical action taken for any purpose while the patient receives care with Lurie Children's.
 - iii. If I am pregnant, I agree that all the provisions in this Consent also apply to my unborn child/children for their care while I am receiving care from Lurie Children's.
 - iv. I understand that Lurie Children's is an academic medical center and its mission includes training healthcare professionals. I agree that physicians, residents, fellows, nurses, technicians and other healthcare professionals in-training may be actively involved in my care and treatment for teaching purposes.
 - v. I understand that representatives from various manufacturers or suppliers of medical equipment and/or devices may be present while I receive care by providers at Lurie Children's. The presence of these individuals is to assist the physicians and other health care providers in my care.
- C. **Photography and recordings by patients:** I understand that I am not allowed to take pictures or record care or treatment provided by Lurie Children's. To respect the privacy of other patients, I understand that I am also not allowed to take pictures or record other patients.
- D. **Personal Property:** I understand that Lurie Children's is not responsible for the loss, theft, or destruction of my personal property, including valuables that I bring with me to Lurie Children's. I release Lurie Children's from responsibility and liability for the loss, destruction or theft of any personal property that I bring with me to Lurie Children's.
- E. **Expiration:** Unless revoked (taken back) or replaced, this form will expire when the patient reaches age 18 or is emancipated. For patients over the age of majority, this form will expire when revoked or replaced.



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II. Using and Sharing My Information

- A. **The Law:** There is a federal law called the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This law requires Lurie Children's to protect the privacy and security of its patients' contact, financial, and treatment information. There are also other laws that require Lurie Children's to take more steps to protect certain categories of health information about: behavioral or mental health; developmental disabilities; treatment for substance (alcohol and/or drugs) use disorder; genetic testing and counseling; HIV/AIDS; sexual assault/abuse; sexually transmitted illnesses; pregnancy; birth control; domestic abuse of an adult with a disability; child abuse and neglect. All together, this information is called your "Health Information".
- B. **Authorization to receive, use, and disclose:**
- i. If my permission is required by law, I agree by signing this form, that Lurie Children's may receive, use and disclose my Health Information for:
 1. The purposes of my care, treatment, care coordination, obtaining payment, and performing business operations. I understand that if a patient is over 12 years of age, the State requires that the patient must also give permission by signing this form, as appropriate.
 2. For the purposes of required disease or other state law reporting requirements.
 3. For purposes of immunization tracking. I-CARE is an immunization record-sharing computer program developed by the Illinois Department of Public Health. I-CARE helps health care providers record, track and report their patients' immunizations. Participation is voluntary. If I prefer not to participate, I must notify: Lurie Children's Health Information Management Department, 225 E. Chicago Ave., Box 11, Chicago, IL 60611; phone 312-227-5220.
 4. The purposes of care, treatment, care coordination and operational purposes with my Other Providers. "Other Providers" may include (but are not limited to) my community-based pediatrician or provider, and my providers with Northwestern Medicine and its affiliates.
 5. "Other Providers" also may include my providers participating in the following data sharing programs like: Epic CareEverywhere®, Epic CarEquality, EpicCare® Link, or other similar data sharing programs. These data sharing programs allow my providers to exchange my Health Information for treatment purposes, including in emergency situations. I am giving my permission to Lurie Children's to send and receive my Health Information electronically with my other providers. If I prefer not to participate, even in an emergency situation, I must notify: Lurie Children's Health Information Management Department, 225 E. Chicago Ave., Box 11, Chicago, IL 60611; phone 312-227-5220.
 6. The purposes of providing MyChart to me, if I activate my account. Lurie Children's offers me access to portions of my Health Information via a Web-based version of Lurie Children's computer systems called MyChart. MyChart is not my complete medical record but includes key tools that will allow me to communicate securely with my care team and manage my health care. If I sign up for MyChart, my Health Information will be disclosed to my parent/guardian, or any other individual that I give access to. I will be provided activation instructions. For more information, see www.luriechildrens.org; or call 312-227-5220.
 - ii. I agree that my permission applies to all my Health Information in Lurie Children's possession, including but not limited to my contact information, problem list, diagnostic test results, medication list, allergy list, immunizations, medical history, surgeries, procedures, and other clinically relevant data.



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- iii. I understand that Lurie Children's cannot control how others that receive my Health Information will protect or use my information. I understand that others may not be required by law to protect my Health Information.
- C. **Operational Purposes:** I agree that the contact information I give to Lurie Children's, such as telephone/fax numbers, cell phone numbers, and email addresses, may be used by Lurie Children's and third parties acting for Lurie Children's to communicate with me for operational purposes including appointment reminders, follow up treatment reminders, flu shot reminders, patient surveys, payment and collections purposes. I understand that I may be contacted by text messages, and auto-dialed or prerecorded messages. I understand that Lurie Children's will not share my telephone numbers except as allowed under the law, for treatment, payment, and healthcare operations, and as permitted by this form.
- D. **Photography and recordings by Lurie Children's:** I understand that photographs, videos and other recordings and images may be important to my care. I give permission for Lurie Children's to take photographs, videos, digital and other images of me for treatment, education and operational purposes. I also give permission for Lurie Children's to use and disclose non-identifiable images externally for these purposes without additional authorization. I understand that all reproduction and all copyrights associated with these images and media are and shall remain the property of Lurie Children's, its successors and/or assigns.
- E. **Revocation:** I may revoke (take back) my permission to share my Health Information, and this Consent, by writing to Lurie Children's Health information Management Department, 225 E. Chicago Ave., Box 11, Chicago, IL 60611. I understand that if I revoke my permission to share my Health Information, it will not apply to any actions taken by Lurie Children's while the Consent was effective.
- F. **Marketing Activities:** I agree that the contact information I give to Lurie Children's, like telephone/fax numbers, cell phone numbers, email and mail addresses, may be used by Lurie Children's and third parties acting for Lurie Children's to communicate with me for marketing activities. If I prefer not to be contacted about marketing, I must notify: Lurie Children's Marketing and Communications Department, 225 E. Chicago Ave., Box 87, Chicago, IL 60611.
- G. **Fundraising Activities:** Lurie Children's relies on fundraising to help support caring for all patients. I give my permission to be contacted to discuss participating in fundraising opportunities. If I prefer not to be contacted about fundraising, I must notify: Lurie Children's Marketing and Communications Department, 225 E. Chicago Ave., Box 87, Chicago, IL 60611.
- H. **Notice of Privacy Practices:** I understand that I can find more information about my rights to my Health Information, and about how Lurie Children's uses my information, in Lurie Children's Notice of Privacy Practices ("NPP"). The NPP is available on Lurie Children's website and upon request.

III. Financial Acknowledgments

A. Payment for Care Services:

- i. I understand that by signing this form, I agree that Lurie Children's will bill my health insurance for the cost of my care. In exchange for the care provided, I assign and transfer and set forth my rights, title and interest to any and all medical reimbursement under my insurance policy, subscription certificate or other health benefit coverage agreement otherwise payable to me to Lurie Children's.
- ii. I understand that insurance coverage varies and that my insurer may not pay for everything or may pay only part of my bill. I understand that my insurer may deny payment for services that are not covered by my plan, or that the insurer decides are not "medically necessary," "experimental," or not covered. While Lurie Children's may take reasonable steps to appeal these denials, I understand that I am fully responsible for payment of all charges not covered by medical insurance. This includes any denial of the insurance claim because I restricted



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Lurie Children's from sharing my information with my medical insurance for payment purposes. This also includes a denial or partial denial of reimbursement due Lurie Children's "out-of-network" status.

- iii. I agree that I am responsible for any expense of Lurie Children's in collecting the amounts guaranteed hereby, including all court costs, reasonable attorneys' fees and all other collection expenses.
 - iv. I give my permission for Lurie Children's to release all medical information that may be necessary for the payment on my behalf for the health care services rendered to the patient named in the Consent.
- B. **Billing Providers:** I understand that care and services provided at a Lurie Children's location may include one or more of the following providers: Ann & Robert H. Lurie Children's Hospital of Chicago, Pediatric Faculty Foundation, Inc., Children's Surgical Foundation, Inc., Pediatric Anesthesia Associates, Ltd., Lurie Children's Medical Group, LLC, Almost Home Kids, Lurie Children's Primary Care, LLC, and each of their physicians, nurses and other personnel. I understand that each provider may bill me separately.
- i. I understand that it is my responsibility to contact my insurance company to determine whether a provider or hospital service will be covered by my insurance. I understand that if I receive "out-of-network" services, I may have greater financial responsibility to Lurie Children's for payment for these services.
 - ii. I understand that even if a service is covered by my insurance plan, I may still be responsible for part of the cost of the service. It is my responsibility to contact my insurance company to determine how much of the cost of the service I will be required to pay.
 - iii. I understand that Lurie Children's cannot guarantee that a service will be covered under my plan. I should contact my health plan if I have questions about my health insurance coverage.
- C. **ERISA:** If my insurance benefits are provided through an ERISA plan or other employer group health plan, I assign, transfer and set forth all my rights, title and interest as a beneficiary of the plan to Lurie Children's, for my care. I also appoint Lurie Children's as my authorized representative to receive plan coverage information and appeal any rights to payment and healthcare benefits. I agree to cooperate and provide information as needed by Lurie Children's to establish my eligibility for my insurance benefits. No group health plan provision will serve to circumvent Lurie Children's right to recoup fees for services from patients.
- D. **Medicaid/Medicare:** If I am applying for payment under Medicare or Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for provider services to the provider (s) or organization furnishing the services or authorize them to submit a claim to Medicare on my behalf.
- E. **Financial Assistance:** If I do not have health insurance or have difficulty paying my bill, Lurie Children's provides financial assistance options, including free care, discounted care or interest-free payment plans. Information about the financial assistance program, qualification criteria and whether or not my physician or other providers offer financial assistance is made available to me during the registration process and upon request.

IV. Research Activities

- A. I understand that Lurie Children's mission includes advancing new knowledge and scientific discoveries through research. Providers and/or researchers may contact me to discuss research opportunities that may be of interest to me. It is my decision whether I agree to participate. If I prefer not to be contacted about research, I must notify: Director, Office of Research Integrity & Compliance, Ann & Robert H. Lurie Children's Hospital of Chicago, 225 East Chicago Ave, Box 205, Chicago, IL 60611.



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- B. I agree that Lurie Children's may use and share my excess tissue or body fluid for educational and research purposes with or without my personal identification in accordance with law.

By signing below, I confirm that I have read, understood and agree to the contents of this form, the Consent. I have been able to ask questions. If I have questions in the future, I understand that I can contact Patient Relations at 312.227.4940; 225 East Chicago Avenue, Box 48, Chicago, Illinois 60611-2603.

All signatures must be provided for the form to be valid:

Signature of Patient age 12 and over

Date

Time

Signature

Date

Time

Relationship (check one): Parent Guardian Legal Representative

Signature of Witness or Employee

Date

Time

Signature/Name of Interpreter if applicable

Date

Time