CONSENT FOR TREATMENT: I hereby consent to the administration and performance of such medical treatments and diagnostic procedures as may be deemed advisable during the course of my hospitalization by my attending physician / emergency physician or his / her designee(s). This General Consent to Treatment is valid for all out-patient ancillary services provided by Kishwaukee Community Hospital (KCH) /Valley West Community Hospital (VWCH) for the period of one (1) calendar year unless otherwise revoked by the patient.

I understand that the Hospital is an institution which provides clinical training opportunities for medical, nursing, and allied health students. These training programs are provided by the Hospital solely and/or in cooperation with other institutions. I understand that the treatment and care provided me at KCH/VWCH may involve one or more students functioning under the direct supervision of my physician(s) and/or duly authorized designee(s) or the registered nurses and therapists assigned to my care.

RELEASE OF INFORMATION: I hereby authorize KCH/VWCH to release to my insurance companies, employer insurance groups, health plans, Medicaid / Medicare program, its insurance carriers or intermediaries, and authorized external review agencies, any medical records or other information concerning this treatment, including this patient authorization record, to process insurance claims and conduct utilization review procedures. It is my full understanding that the information /documentation to be disclosed may include sensitive information such as evaluation/treatment information for mental health, developmental disabilities, HIV and/or alcohol/ substance abuse/use unless specifically checked for exclusion: [ ]mental health, [ ]substance use/abuse, [ ] HIV [ ] developmental disabilities.

I authorize the release of medical information to health care providers in the continuum i.e. homecare, hospice, skilled care, durable medical equipment providers and Rehab services for the purpose of evaluating, planning and providing my continuing care upon release from the hospital.

PHYSICIAN SERVICES: I understand that I am financially responsible for the professional services of radiologist(s), pathologist(s), cardiologists, anesthesiologist(s), and other physician charges which are not billed by the hospital. **Physicians providing care are independent practitioners and are not employees or agents of KCH/VWCH.** I hereby authorize my third party payor to directly pay the above named parties or their service corporation. I hereby authorize release of information requested by insurance / billing agencies to the above named parties. _____ (Patient Initials).

MEDICARE: If I am an inpatient Medicare beneficiary, my signature only acknowledges that I have received a copy of "An Important Message from Medicare" from KCH/VWCH and does not waive any of my rights to request a review or make me liable for any payments. If I wish to exercise my right to request a review by the Quality Improvement Organization (QIO), I must have a "Notice of Noncoverage".

COMPLAINTS OR GRIEVANCES: Concerns, complaints or grievances about your care or treatment can be directed to *any* hospital staff person, Department Manager or Hospital Supervisors. You may also dial "0", and the hospital operator will direct your call to the appropriate party to address or resolve your concern. You may also contact the Illinois Department of Public Health, 217.782.4977, 525 W. Jefferson St., 5th Floor, Springfield, IL 62761, TTY 800.5470466; or the Guardianship and Advocacy Commission, 815.987.7657; or The Joint Commission,1.800.994.6610 (or complaint@jointcommission.org) regardless of whether you have reported your complaint to the hospital. Additional patient rights information is located in the patient rights brochure, or on the hospital website (kishhospital.org or vwch.org). _____ (Patient Initials)

FINANCIAL AGREEMENT AND PAYMENT GUARANTEE: I hereby assign KCH/VWCH all of my rights and claims for reimbursement under any Medicare, Medicaid, or other insurance policies for which benefits may be available for payment of services provided. I agree to pay KCH/VWCH the balance due of all charges not paid for by the above-mentioned coverage (excluding those charges not collectible pursuant to Medicare regulations). This may include the cost of collection and / or reasonable attorney's fees not to exceed the State's common usury fee schedule. This may also include review of my credit report. The hospital has an obligation to obtain credit information based upon the fact that services were provided which will allow for collection of the account and my authorization for these services creates a valid consumer transaction.

- I agree to provide the hospital with a valid telephone number (cell, wireless, and/or land line) in order to grant us and/or our agents or independent contractors your consent to receive calls for any billing and collection purposes.
- I have been made aware that information about the billing and payment policies is located in the Patient Guide.

RELEASE FROM RESPONSIBILITIES FOR VALUABLES: I understand that the hospital does not assume responsibility for personal possessions that are not placed in the hospital safe.

NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practices from KCH/WVCH either today or since April 14, 2003, which completely describes how my health information is used and shared.

Signed _____ Date _____

Relationship _____ Witness: _____

If signed by other than patient or patient consent unable to be obtained, check reason:

☐ **Patient non-responsive** ☐ **Patient confused/disoriented** ☐ **Patient has been sedated** ☐ **Other:** _____

KISHWAUKEE HEALTH SYSTEM

Kishwaukee Community Hospital & Valley West Community Hospital [7/05, 9/06, 7/07, 2/09, 12//09, 2/11]

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PATIENT AUTHORIZATION RECORD

Inpatient / Outpatient