Indiana University Health | IU Health Medical Group

Consent for Treatment and Payment Responsibility English

Patient Label

AUTHORIZATION FOR TREATMENT: I authorize IU Health hospitals and/or its affiliated entities (collectively, "IU Health"), Physicians and Advanced Practice Providers, (collectively, "Providers"), and their agents and employees—to provide me with medical, mental health, and surgical care, including tests, exams, procedures, drugs, and any other necessary treatment (collectively referred to as "Health Services"). I understand and agree my care may be provided in person or through a virtual visit or telehealth. I agree no one can guarantee results or cures. I understand IU Health is part of a teaching environment, and at times, students, residents, and fellows may be involved in my care and may perform part or all of a procedure or examination. I attest I have the legal right to consent to treatment for this patient.

ASSIGNMENT OF BENEFITS & PAYMENT RESPONSIBILITY: I give IU Health permission to give my medical records and information to insurance providers or other third-party payers to receive payment for Health Services provided by IU Health. I assign payment otherwise payable to me from Medicare, Medicaid, insurance carriers, employees health benefit plans, and other third-party payers (collectively referred to as "Plans") to IU Health. I understand I am responsible for knowing the limits of my Plan benefits and agree to be personally responsible for paying for Health Services provided to me, including any amount not paid by my Plan, consistent with any applicable, written, contractual discounts and IU Health's patient financial assistance policies. I am responsible for following all insurance policy rules. I understand charges may be based upon IU Health's chargemaster and accept those charges as being reasonable. I know that if I do not pay what I owe to IU Health, they may send the matter to a collection agency or attorney; I understand and agree to be responsible for all collection costs, including reasonable attorney's fees, court costs, and interest. I understand that any overpayments, deposits, and/or credits may be applied to any other outstanding account balances with IU Health prior to receiving a refund.

DISCLAIMER: Patient's payer identification card is for informational purposes only. Contracts for payment and reimbursement must be agreed to in writing by both payer and IU Health. Any attempt to establish a contract or vary the terms of a contract with provisions contained on a patient's payer identification card is disclaimed and rejected.

INDIANA LAW AND JURISDICTION: I understand I am receiving Health Services from an Indiana health care system. If I choose to raise a dispute related to my care or billing in court, I agree the case must be filed in an Indiana court, and Indiana law will apply.

COMMUNICATIONS CONSENT: I expressly consent and agree IU Health may use health information about my Health Services for a range of purposes, including billing and collecting moneys due from me. IU Health's employees, business associates, and other third parties acting on its behalf may contact me with information relating to my care, including: appointment reminders; scheduling or registration; alerts about preventative services and other treatment options; information regarding insurance, billing, eligibility, and/or collections; health-related promotional information that might be of interest to me; or other reminders and alerts that may be helpful in coordinating/continuing my health care. I expressly consent and agree to be contacted at the phone number (including mobile, cellular/wireless or similar devices) I provide below, including by text (SMS), for which my telecommunications carrier may charge data usage fees (including additional charges when roaming). I can contact my wireless carrier for complete pricing details. The ways in which IU Health may contact me include live operator, automatic telephone dialing systems (auto-dialer), artificial or prerecorded message, or text/SMS message.

By providing my phone number to IU Health without conditions, whether directly or through an intermediary, verbally, electronically, or in writing, IU Health may contact me by phone (described above), and/or text (SMS) regarding my Health Services, such as appointment reminders, education, patient experience and care inquiries, and billing services, including for purposes of collecting moneys due from me. By signing below, I agree that IU Health may call my phone (described above), and/or text (SMS) for marketing or solicitation about IU Health's or their third-party partners' products and services related to medical care that IU Health thinks would be of interest to me, including for research recruitment purposes by IU Health and Indiana University. I understand I am not required to sign or agree to enter this communications consent as a condition of purchasing any property, goods, or services.

This agreement will remain in place unless I revoke my consent. To do so, I must: (1) send IU Health a written notice stating that I am revoking my prior consent, (2) include my name, mailing address, and the last four digits of my account number; (3) specify whether I would like communications to stop by phone call, text/SMS, or both; (4) provide the specific phone number(s) to which this applies; and (5) mail the notice to IU Health, Attention Customer Service, 250 N. Shadeland Ave., Indianapolis, Indiana 46219.

I AGREE WITH THE ABOVE COMMUNICATIONS CONSENT: ☐ YES ☐ NO	DATE/TIME	PHONE NUMBER

****Please see the following for IMPORTANT NOTICES, including a plain language summary of IU Health's Hospital Financial Assistance Policy****

ATTENTION: Please read entire form before signing. Changes will not be accepted on this form. By signing this, I agree that I have read everything in this Consent and agree everything in this Consent will apply to current and future Health Services provided by IU Health.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE	DATE/TIME	RELATIONSHIP
SIGNATURE OF GUARANTOR (IF OTHER THAN PATIENT/LEGAL REPRESENTATIVE)	**DATE/TIME**	**RELATIONSHIP**

REFERRALS: Your provider may have referred you to an out-of-network provider for health care items or services. An out-of-network provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under your health plan. You may contact your health plan before receiving health care items or services rendered by an out of network provider to obtain a list of network providers that may render the health care items or services and for additional assistance.

RELEASE OF INFORMATION: Current and/or previous providers may share your medical records with IU Health to facilitate your health care. IU Health may use minimally necessary medical records for your health care. IU Health may share your minimally necessary medical information with family members and friends involved in your care to make decisions about your care, if you are unable to do so or give permission. IU Health may share your medical records with third-party payers, insurance companies, review agencies, employers, welfare departments, and third-party data service providers such as health information exchange programs. You have the right to request a restriction of your health information by contacting Health Information Management.

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At any time, you may change this by giving written notice to IU Health's Health Information Management department at 1701 N Senate Blvd., Indianapolis, IN 46202. The IU Health hospital may list you in its directory and give your name, hospital location, health condition expressed in general terms, and religious preference to third parties unless you state otherwise. You may designate a lay caregiver (the person who, if needed, upon release, will assist you with your aftercare) to the individual providing you with this consent or to your medical care team before release from the hospital. If you designate a lay caregiver or if one is designated for you, your caregiver may receive copies of your discharge plan of care and patient education to assist with your care upon release from the hospital. If you want your designated caregiver to receive more information, you will be required to fill out an Authorization to Release form. HIPAA: IU Health's and/or Provider's Notice of Privacy Practices has been given or made available.

USE AND DISPOSAL OF BODY PARTS: IU Health is a research and teaching institution and is permitted to use body parts removed from procedure(s), including organs, tissue, bone, or bodily fluids, for these purposes. Your data and body parts will be treated carefully, so you cannot be identified, except as required by law. You do not legally own your body parts after removal and have no rights to the research products from these parts.

PICTURES AND RECORDINGS: Audio and video recording of your care will be for IU Health use only or as allowed by law. You will be asked to sign a separate consent if recordings and pictures are used for other purposes. You are not allowed to record or photograph without IU Health's prior consent.

INFECTIOUS DISEASE TESTING: IU Health tests for infectious diseases. This may include hepatitis and human immunodeficiency virus (HIV). You authorize IU Health to test for these infectious diseases if ordered by a Provider. You understand that you may opt out of such screening practices.

INDEPENDENT PROVIDERS: Many Providers, such as Emergency, Radiology, Anesthesia, Pathology, and Hospitalist Providers, who care for you at an IU Health Hospital are INDEPENDENT PROVIDERS and are not subject to the control and supervision of the Hospital.

PERSONAL BELONGINGS: IU Health is not liable for loss, theft, or damage of your personal belongings. IU Health wants belongings of value sent home, but you can keep certain belongings with you AT YOUR OWN RISK AND AT YOUR OWN EXPENSE, AND NO ONE AT IU HEALTH CAN CHANGE THIS RISK. IU Health, including its employees and IU Health police, has the right to search any of your things on the premises, including purses and wallets, for the safety and welfare of its patients and visitors. You can avoid having your things searched by sending them home. If IU Health decides an item could be a threat to health or safety, IU Health may provide for removal from the patient environment and appropriate storage.

ESTIMATES: You can request an estimate for the cost of non-emergency medical services provided at IU Health locations. To request an estimate, contact an Estimates Team Member at 317.963.2541 or 833.722.6050 (toll free) or Estimates@IUHealth.org.

ADVANCE DIRECTIVE: If you wish to provide an Advance Directive or if you have questions about them, you can inform an IU Health Hospital's Registration personnel, and someone from nursing and/or chaplaincy will follow up with you.

SUMMARY OF INDIANA UNIVERSITY HEALTH HOSPITAL FINANCIAL ASSISTANCE POLICY

Financial assistance is available to qualifying all patients receiving care at an IU Health hospital location. If you are uninsured, you will receive a discount and be billed only the amount that is generally billed to patients with insurance coverage at that IU Health hospital facility. If you receive a medically necessary service that your insurance does not cover, you may receive a discount similar to the discount received by uninsured patients. If you enter into a pre-negotiated agreement with IU Health for payment of services, you will not qualify for financial assistance under this policy.

If you are an Indiana resident, as defined in the IU Health Financial Assistance Policy, who receives care via the emergency department, direct admission from a Provider's office, or transfer from another hospital, you may be eligible to receive additional assistance if paying your medical bills is a financial hardship and you apply. If you meet the Federal Poverty Level (FPL) criteria below, you may be eligible for financial assistance up to the full amount of your medical bill.

# of Adults in Household	# of Dependents in Household	FPL Income Threshold
1+	0	200%
2+	1+	250%
1	1+	300%

If your income is above these levels but the amount you owe is more than 20% of your annual household income, you may be eligible for a discount to reduce your patient balance to 5% of your annual income.

No patient approved for financial assistance due to financial hardship will be charged more than the amounts generally billed to patients who have insurance coverage for similar care provided at the respective IU Health hospital facility where the patient received services.

Complete Financial Assistance Applications must include all required attachments and information in order to be considered. IU Health may determine that you qualify for additional assistance and aid you in the completion of an application for state assistance programs including Medicaid and the Healthy Indiana Plan. If financial assistance is approved, you will receive written notification and an updated statement with your reduced balance.

The IU Health Financial Assistance Application, Financial Assistance Policy and a summary of IU Health financial assistance are available for free at the registration desk at any IU Health location or online at www.iuhealth.org/financialassistance. The policy, application, and this plain language summary are available to download or print in English as well as the following languages: Arabic, Burmese, Hakha Chin, Karen, Mandarin Chinese, and Spanish.

To learn more about available financial assistance, the application process, request an enrollment appointment with a certified Financial Navigator, or request a free copy of the application materials by mail, please contact us at 1-888-531-3004 or seek assistance at the registration desk at any IU Health location.