IU Health Medical Group

Patient Label

General Consent for Professional/Clinic

AUTHORIZATION FOR TREATMENT: I authorize this Clinic and/or its associated entities; Physicians and Advanced Practice Providers, (collectively, "Providers"); and their agents and employees to provide me with medical, mental health, and surgical care. This may include: tests, exams, procedures, drugs, and any other necessary treatment. I understand and agree that my care may be provided through a virtual visit or telehealth. I agree that no one can guarantee results or cures. I understand Providers are part of a teaching environment, and at times, students, residents, and fellows may be involved in my care. I attest that I have the legal right to consent to treatment for this patient.

ASSIGNMENT OF BENEFITS & PAYMENT RESPONSIBILITY: I give Providers permission to give my medical records and information to insurance providers or other third-party payers to receive payment for services, care, or treatment (collectively referred to as "health services") provided by Providers. 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 Providers. 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 the Providers' patient financial assistance policies. I am responsible for following all insurance policy rules. I understand charges may be based upon the clinic's chargemaster and accept those charges as being reasonable. I know that if I do not pay what I owe to Providers, 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 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 the Hospital. 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 that I am receiving care from an Indiana health care system. I agree that if I choose to raise a dispute related to my care or billing, the case must be filed in an Indiana court, and I agree Indiana law will apply.

COMMUNICATIONS CONSENT: You expressly consent and agree that Providers may use health information about your medical care for a range of purposes, including billing and collecting moneys due from you. Providers' employees, business associates, and other third parties acting on its behalf may contact you with information relating to your 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 you; or other reminders and alerts that may be helpful in coordinating/continuing your health care. You expressly consent and agree to be contacted at the phone number (including mobile, cellular/wireless or similar devices) and/or email address you provide below, including by text (SMS), for which your telecommunications carrier may charge data usage fees (including additional charges when roaming). Please contact your wireless carrier for complete pricing details. The ways in which we may contact you include live operator, automatic telephone dialing systems (auto-dialer), artificial or prerecorded message, text/SMS message, or email.

By providing your phone number and/or email to us without conditions, whether directly or through an intermediary, verbally, electronically, or in writing Providers may contact you by phone (described above), text (SMS), and/or email communications to perform your medical care and services related to your medical care, such as appointment reminders, education, patient experience and care inquiries, and billing services, including for purposes of collecting moneys due from you. By signing below, you agree that we may call your phone (described above), text (SMS), and/or send email communications for marketing or solicitation about Providers' or our third-party partners' products and services related to medical care that we think would be of interest to you, including for research recruitment purposes by the Hospital and Indiana University. *You understand you are 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 you take steps to revoke your consent. If you wish to do this, you should: (i) provide Providers with written notice revoking your prior consent, (ii) include your name, mailing address, and the last four digits of your account number; (iii) advise whether you would like communications to cease via phone call, text/SMS or email; (iv) provide the specific phone number(s) and email address; and (v) send the notice to Providers, 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 following for IMPORTANT NOTICES*****

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 that everything in this Consent will apply to current and future health care services provided by Providers.

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

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RELEASE OF INFORMATION: Current and/or previous providers may share your medical records to Providers to facilitate your health care. The Providers may use minimally necessary medical records for your health care. Providers 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. Providers may share your medical records to 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, 1701 N Senate Blvd., Indianapolis, IN 46202. At any time, you may change this by giving written notice to Providers.

HIPAA: Providers' Notice of Privacy Practices has been given or made available.

USE AND DISPOSAL OF BODY PARTS: Providers are part of a research and teaching institution and are 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 Providers' 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 Providers' prior consent.

INFECTIOUS DISEASE TESTING: Providers test for infectious diseases. This may include hepatitis and human immunodeficiency virus (HIV). These tests may be ordered by a Provider if one of your caregivers is exposed to your bodily fluid.

PERSONAL BELONGINGS: Providers are not liable for loss, theft, or damage of my personal belongings. Providers want 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 Providers CAN CHANGE THIS RISK. Providers, including Providers' employees and agents, such as security, 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 leaving them at home or in a vehicle. If Providers decides an item could be a threat to health or safety, Providers may provide for removal from the patient environment and appropriate storage.

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.

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