Consent to Treatment: I have a condition requiring examination, diagnosis, and/or treatment and hereby consent to and authorize such customary care including, but not limited to: x-ray, laboratory, routine diagnostic tests and therapeutic procedures ("Services") performed by my admitting and treating health care provider(s) ("Providers"), who may or may not be employed by CHI Memorial Health Partners Foundation and his or her assistants or designees, including personnel employed by CHI Memorial Health Partners Foundation. I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this and for CHI Memorial Health Partners Foundation to retain ownership rights to these images. A separate consent for photography form will be obtained for disclosure of any images outside of CHI Memorial Health Partners Foundation that identify me and are used for purposes such as education or marketing. I understand that such care may involve risks and that no guarantees have been made to me concerning the results of this treatment or examination. I further understand that I have the right to make decisions concerning my health care, including the right to refuse medical and surgical procedures/treatment. For any notice or authorization referenced herein, a copy of this form can be used in place of the original.

Clinical Education and Research: I agree to the supervised participation of health care learners (e.g., medical students, nursing students, interns, residents, fellows, other clinical students, etc.) in my care. I understand that patient records and specimens obtained from my body for medical care purposes may be used in research. Research involving records and specimens will be conducted in such a manner that patients cannot be identified without their written consent. No other treatment, procedure or studies will be performed solely for research purposes without the separate written informed consent of the patient.

Permission to Photograph: I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this and for CHI Memorial Health Partners Foundation to retain ownership rights to these images. A separate "consent for photography" form will be obtained for disclosure of any images outside of CHI Memorial Health Partners Foundation that identify me and are used for purposes such as education and marketing.

Independent Status of Providers: I recognize that not all health care providers who provide Services to me during this admission are employees or agents of CHI Memorial Health Partners Foundation. Such individuals are INDEPENDENT CONTRACTORS who are granted privileges to use CHI Memorial Health Partners Foundation for private Patients and bill separately for their services. In addition, I understand that CHI Memorial Health Partners Foundation is not responsible for nor does it assume any liability for the acts or omissions of any such independent contractors.

Assignment of Facility and Professional Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to CHI Memorial Health Partners Foundation or Providers and authorize direct payment to CHI Memorial Health Partners Foundation or Provider, as the case may be. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.

Authorized Representative: I hereby authorize CHI Memorial Health Partners Foundation, its agents or representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for Services provided to me.

Financial Responsibility: I understand that I am financially responsible to CHI Memorial Health Partners Foundation as the patient, parent, guardian, conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, out-of-pocket expenses, or the extra cost of a private room in which I am placed at my own request. I authorize the CHI Memorial Health Partners Foundation or Provider(s) to access and review my credit report for purposes related to billing or collection of accounts.

Pharmacy Health Information Exchange:
I consent to CHI Memorial Health Partners Foundation obtaining my medication history information electronically through a pharmacy health information exchange for appropriate care and to avoid adverse drug reactions.

Communications Consent: By providing my cell, landline, or any other numbers(s), I expressly consent to receiving communications from CHI Memorial Health Partners Foundation, its staff, its contractors, collection agents, and others, at any number I provide. CHI Memorial Health Partners Foundation may use this information to contact me by live agent, voice mail, text message, using an auto-dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose, including but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that, depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving the Services.

Personal Equipment and Valuables: I understand that CHI Memorial Health Partners Foundation maintains a safe for the safekeeping of money and valuables. I understand that CHI Memorial Health Partners Foundation shall not be liable for the loss or damage of my personal property. I accept full responsibility for all property kept in my possession. I also understand that I must inform the admissions clerk or a nurse if I bring any electrical equipment to CHI Memorial Health Partners Foundation (e.g. ventilators; BIPAP machine, CPAP machine) and adhere to CHI Memorial Health Partners Foundation policies regarding its use. I assume full responsibility for such electrical equipment and for any injury caused by the use of the electrical equipment brought from home.

Acknowledgment of receipt of notice of privacy practices, patient rights and responsibilities information.
Please Initial: _______ I acknowledge that I was provided with a copy of the Notice of Privacy Practices and Information about my patient rights and responsibilities.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent or is duly authorized by or on behalf of the parent to execute the above and accept its terms.

Patient's Signature/Parent if Minor/Power of Attorney/Guardian	Relationship	Date/Time
Responsible Party's Signature (If Not Same as Patient or Parent)	Responsible Party's Signature	
Witness to Signature	Patient Unable to Sign Consent Because	
Name and/or ID of Interpreter, if used/applicable		