UNIVERSAL CONSENT

imprint

☐ Carle Foundation Hospital_____
☐ Carle Physician Group_____
☐ Carle Hoopeston Regional Health Center_____
☐ Carle Richland Memorial Hospital_____

CONSENT

Patient Name:_____

Date of Service:_____ MRN:_____ DOB:_____

Throughout this document the reference to "Carle" collectively refers to Carle Foundation Hospital, Carle Physician Group, Carle Hoopeston Regional Health Center, and Carle Richland Memorial Hospital.

CONSENT FOR TREATMENT

I consent to the provision of care, diagnostic procedures, laboratory testing and medical treatment as my physician(s) and/or other healthcare provider(s) deem necessary. If surgery, complex diagnostic, therapeutic procedures and/or blood or blood products are required, my practitioner will discuss these with me and additional informed consent may be obtained. I understand that there are no warranties or guarantees regarding the services and care provided. Some care may be provided using telehealth technology and I consent to participate in telehealth consultations. I consent to the taking of photographs or video recordings that document conditions, treatments or procedures and understand that such images will be used for medical, scientific or teaching purposes only. Information I provide regarding religious affiliation will be available to clergy affiliated with my congregation unless I indicate otherwise to admission staff. Upon completion of testing, specimen(s) or other material(s) obtained from my procedure(s) or treatment(s) may be disposed of or retained by Carle for scientific or teaching purposes or may be used by Carle or third parties for test validation or research purposes. If my specimen(s) or other material(s) are provided to third parties, the specimen(s)/material(s) will be made anonymous and its original source no longer able to be identified.

I understand that the providers participating in my care, including my physician, may be either employees of Carle or independent contractors who are not employees or agents of Carle. I understand that the providers participating in my care have been granted the privilege of using Carle facilities for the care and treatment of their patients or are licensed practitioners participating in the care of patients as part of a post-graduate medical education program. I understand that as a teaching institution, medical residents and clinical students may participate in my care unless I request otherwise. Carle will attempt to honor the request to exclude a resident or clinical student where feasible and if such exclusion will not be detrimental to my healthcare.

RELEASE AND SHARING OF RECORDS

I understand Carle may share records, charts, x-rays, laboratory work or similar information regarding my medical care with other Carle entities for the purposes of my treatment. Carle may release any medical records related to this medical visit to my Primary Care Physician and/or other providers who participate in my care. I acknowledge that Carle shares its electronic medical record system with other healthcare entities through the Community Connect program. When I am treated by practitioners using this combined system, those individuals will have access to my medical information and use the same medical record system to document information about care and services for purposes of continuity of care. Once my information is combined, it cannot be separated. I understand and acknowledge that Federal and State laws require certain medical conditions/diseases to be reported to State and/or Federal agencies. Such conditions/diseases include, but are not limited to, HIV/AIDS, tuberculosis, viral meningitis and sexually transmitted diseases.

ASSIGNMENT OF INSURANCE BENEFITS AND INSURANCE COMMUNICATIONS

I authorize Carle to bill my insurance(s) directly. I authorize my insurance(s) to make payments directly to Carle for all services provided, but not exceeding the charges due. Should my care require prior authorizations, referrals, claims appeals, reconsiderations, peer-to-peer reviews, or post-determination reviews by my insurance, I give Carle permission to communicate with my insurance(s) on my behalf.

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES

I have received and reviewed a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities, made available to me as a handout or as part of the Patient Registration and Admitting Information Booklet.

PAYMENT AGREEMENT

I assume full responsibility for and agree to pay all costs, charges and expenses incurred by me for the medical care provided by Carle, whether as an inpatient or outpatient unless I qualify for financial assistance or charity care. If my medical insurance coverage is not sufficient to satisfy such costs, charges and expenses in full, or I do not follow guidelines of my insurer and the resulting balance is not covered, I will be fully responsible for payment of this balance.

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CONSENT

CONSENT TO RECEIVE AUTO-DIALED MESSAGES/CALLS

I hereby consent to receive auto-dialed and/or artificial or pre-recorded message calls and/or text messages to my cellular phone number and any other telephone number that I have provided or will provide or that is available to Carle from third parties. I authorize Carle and/or their affiliates and agents, including without limitation, any account management companies, debt collectors, appointment reminder software, and/or general messaging services to use automated dialing technology and pre-recorded messages, phone calls or texts even if I am charged for the call or text under my phone plan. I agree that any such contact is not considered "unsolicited" for purposes of local, state, or federal law.

ILLINOIS FAIR PATIENT BILLING ACT (210 ILCS 88/50)

Depending on the services I receive today, I understand that I may receive separate bills for services provided by Carle Hoopeston Regional Health Center, Carle Foundation Hospital, Carle Physician Group, Christie Clinic Providers, Carle Richland Memorial Hospital, and/or other providers outside Carle who provide health care services. Further, I understand that some health care providers may not be participating providers with the same insurance plans and networks as Carle. As a result, I understand that I may have a greater personal financial responsibility for services provided by health care professionals who are not under contract with my health plan. I understand that questions about my coverage or benefit levels should be directed to my health insurance carrier. I may contact a Customer Service Representative at (888) 712-2753 or (888) 71-Carle with any questions about my bill.

RELEASE AND WAIVER

I understand that some healthcare professionals providing services are not employees or agents of Carle. These individuals wear a unique identification badge issued by Carle with the name of their employer and/or a badge issued by their own employer with that company's logo. Independent, non-employed medical providers have been granted privileges to provide medical care and treatment to his/her patients at Carle. As such, independent, non-employed providers are not subject to the supervision or control of Carle. I also understand that independent practitioners may bill separately for their services.

I have read (or had read to me) and understand the above information and agree to its content.

Signature of Patient or Authorized Person	Date	Time
Signature of Witness	Date	Time

INTERPRETER SERVICES

I have provided interpretation in _____ *(type of language)* of any verbal and/or written information, including this consent form, that have been provided to the patient/authorized person to consent.

Interpreter Name *(print full name)*	Badge #	Date	Time
Signature *(or if remote source, indicate company used)*			

Carle

DISCRIMINATION IS AGAINST THE LAW.

The Carle Foundation complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Carle Foundation does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Carle Foundation provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats *(large print, audio, accessible electronic formats)*

The Carle Foundation provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages.

If you need these services, contact Carle interpreter services at (217) 326-0340.

If you believe that The Carle Foundation has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Carle Patient Relations at (217) 326-8560 or toll free (855) 665-8252, by email at patient.relations@carle.com or by mail at Carle Foundation Hospital, Attention: Patient Relations, 611 W. Park Street, Urbana, IL 61801. If you need help filing a grievance, Patient Relations is available to help you, M-F 8am-5pm. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, (800) 368-1019 or (800) 537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SPANISH
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-217-383-2543.

CHINESE (MANDARIN)
注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-217-383-2545.

VIETNAMESE
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-217-383-2546.

KOREAN
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-217-383-2547 번으로 전화해 주십시오.

TAGALOG
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-217-326-0340.

RUSSIAN
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-217-326-0340.

ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-217-326-0340

FRENCH
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-217-383-2544.

POLISH
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-217-326-0340.

ITALIAN
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-217-326-0340.

GERMAN
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-217-326-0340.

HINDI
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-217-326-0340. पर कॉल करें।

GUJARATI
સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-217-326-0340.

URDU

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-217-326-0340

GREEK
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-217-326-0340.

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