AdvocateAuroraHealth®

Consent to Treat, Payment and Notice of Privacy Practices
(Use for ambulatory, non-hospital services)

To Treat:

I, for myself, (or the patient named below) hereby consent to and authorize medical treatment which may include the performance of examinations, treatments and diagnostic procedures which the physicians(s) or other appropriate providers at Advocate Aurora Health have advised me of and deemed medically necessary. I understand that health care providers in training may, under the supervision of appropriate personnel, participate in my treatment.

Release of Information:

I hereby authorize Advocate Aurora Health to release any medical information deemed necessary to process insurance claims (including information relating to the treatment of drug abuse, alcohol abuse, or mental illness).

Authorization of Payment:

I further authorize payment of any health insurance benefits directly to Advocate Aurora Health for services rendered to me or my dependent. This authorization applies to any insurance benefit that was in effect at the time the services were provided.

Payment:

I hereby agree to pay in full any balance on my account in accordance with the Advocate Aurora Health Payment and Credit policies, which may include reasonable attorney's fees. The balance due includes provisions set by my insurance company such as copayments, deductibles, and "usual and customary" allowance. Advocate Aurora Health reserves the right to change fees and policies without notice.

Independent Provider Services:

I acknowledge and fully understand that only those physicians/providers who are clearly identified as Advocate Aurora Health employees are agents of Advocate Aurora Health. Non-employed physicians/ providers are independent providers who are permitted to use Advocate Aurora facilities to render medical care and treatment. These independent physicians/providers exercise their own medical judgment in treating me or otherwise providing professional services to me. I understand that I should ask my physician any questions I have about his/ her employment status. My decision to seek medical care is not based upon any understanding, representation, advertisement, media campaign, inference, presumption or reliance that the physicians/providers caring for me are employees or agents of Advocate Aurora Health.

Notice of Privacy Practices and Rights and Responsibilities:

I acknowledge that Advocate Aurora Health has provided me a copy of its Notice of Privacy Practices. I understand the Notice describes Advocate Aurora's privacy practices regarding the use and/or disclosure of patient health information. I acknowledge that I have received verbal and written notice regarding my rights and responsibilities as a patient.

By my signature below, I acknowledge that I have read understand and agree to be bound by the terms of this consent form, including the specific language related to independent physician services. I have had the opportunity to ask questions, and that any questions have been satisfactorily answered.

Date	Time	Patient Signature	
Date	Time	Legal Representative	Relationship to Patient

Interpreter Assistance: If an interpreter assisted, please complete the following: Language: _____

Date	Time	Interpreter Name	ID#