

## General Consent for Service

This consent applies to all medical staff, hospitals and other places listed at the bottom of this page. Signing this consent means that I agree with the statements below. If I am pregnant, my consent also applies to any baby I give birth to at one of these places.<sup>1</sup>

**Treatment:** I agree to medical treatment. I understand I will have a chance to talk with my Medical Team about my treatment. The team may include medical residents and students who work under my Medical Team.

I understand that my Medical Team:

- May collect facts about my health and family health history.
- Will answer my questions about treatment.
- Can't promise exact results from my treatment.

I understand that I may refuse any treatment.

I understand that if I need emergency care at a hospital,<sup>2</sup> my Medical Team will give care to make me stable. They will give me this care even if I have no insurance or cannot pay.

**Assignment of insurance benefits:** I agree my Medical Team may bill my insurance or other payer. Payments may be made directly to my Medical Team. My Medical Team may share my health and account records with payers and their agents as needed for billing, payment and claims. This includes quality reviews and questions my insurance plan may have about my care.

I will pay all charges and amounts for services **not** paid by a third party (such as an insurance company), even if my insurance or benefit card says otherwise.<sup>3</sup>

My insurance plan may need to approve certain treatments before I have them. This approval may be called prior authorization or referral authorization. If I don't get my insurance to give approval, they may not pay for the treatments. If I don't want my insurance billed, I will tell my Medical Team.

If I need help paying for my care, I will ask about my options when I register. I may be screened to see if I can get help paying my bill.

**Health information:** I understand that my health information<sup>4</sup> may be shared with or requested from:

- Doctors, nurses, and other health care staff, agencies and people who give me health care services, both within and outside the Fairview system.
- Health care staff or agencies who refer me to services or coordinate my care.
- Outside agencies who need to see my information to carry out health care operations. These could be business operations, quality improvement, licensing or accreditation or accountable care organizations and networks.

**Notice of Privacy Practices:** I have seen my Medical Teams' *Joint Notice of Privacy Practices*. This *Privacy Notice* explains my rights to my medical information. It also describes in detail how that information may be used and shared. There are some uses and sharing that do not require my consent. If I would like a copy of the *Privacy Notice* to take home, I will ask the staff for a copy.

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1. This consent applies to Fairview Health Services, HealthEast facilities and services, Range Regional Health Services, Grand Itasca Clinic & Hospital, M Health Fairview, and University of Minnesota Physicians.

2. Defined in the Emergency Medical Treatment and Active Labor Act.

3. Information on charges, including a listing of current, standard charges, can be found at <https://www.fairview.org/billing>.

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4. Health records include information about mental and physical health, health care, payment for health care and demographics.

**Research:** Research leads to new and better ways to provide care and diagnose and treat disease. If I allow use of my health records for research, I understand it will be handled as directed by state and federal laws to protect me.

If I do NOT agree to the use of my health records in research, I will check this box.

**Electronic Health Information Exchange (HIE):** I understand that the HIE tells my Medical Team where I've had care and what prescribed medicines I take so that they can get facts to help treat me without asking for printed records. I agree that my Medical Team may get or share my health information from an HIE or similar database service.

If I do NOT wish my Medical Team or other Medical Teams who treat me in the future to get or share my health information through an HIE, I will check this box.

**Consent for payers to share information:** I agree that my insurance plan may share my health and account records from other providers as needed with my Medical Team. They may do this to manage my care and to give me better care.

If I do NOT wish my insurers to release my health and account records as described above, I will check this box.

**Telephone, e-mail or text messages:** My Medical Team may call, e-mail or send text messages for appointment and billing reminders and for healthcare messages such as patient satisfaction surveys to the contact information I provide. My Medical Team may use an automated dialing system and play recorded messages when they call me. I understand I can update my contact information or unsubscribe to electronic communication at any time.

**Photos and videos:** My Medical Team may take photos or videos for treatment or teaching purposes. I will tell my Medical Team if I don't want photos or videos taken of me. I understand that video monitoring is used onsite for clinical, operations and safety reasons. These images are only visible to authorized personnel and are not routinely saved. If the images are saved for an authorized purpose, such as quality improvement, they are stored confidentially and released only with proper authorization.

**Valuables:** I am responsible for my own personal belongings and valuables. My Medical Team is not responsible for any loss or damage to my personal items.

**If I have concerns with this consent, I will discuss them with the staff member who is helping me with this form. I understand that this consent remains in effect until I cancel it in writing. I also understand that any actions already taken while my consent was in effect can't be undone. I understand that no changes to this form can be accepted.**

My signature below shows that I agree with this Consent.

\_\_\_\_\_

*Patient or authorized decision-maker*

*Relationship to patient*

*Date*

*Time*

Print name: \_\_\_\_\_

**This form must be signed by the patient (rather than another person) unless the patient lacks mental capacity to make decisions or physical capacity to sign.**

Interpreter name, if used: \_\_\_\_\_ Language \_\_\_\_\_

Organization: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

*FIIRO GAAR AH: Hadii aad ku hadasho Soomaali, waaxda luqadaha, qaybta kaalmada adeegyada, waxay idiin hayaan adeeg kharash la'aan ah. So wac 612-273-3780.*

*ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-273-3780.*

**We comply with applicable federal civil rights laws and Minnesota laws. We do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender or gender identity.**