Aurora Health Care®

This Treatment Agreement cannot be revised.
Any attempt to do so shall have no effect.

General Consent to Care

I consent to medical care and treatment as ordered by my physician(s). My consent includes all hospital services, diagnostic procedures and medical treatment rendered including, without limitation, examinations, x-rays, laboratory procedures and other tests, treatments and medications, monitoring, electrocardiograms (EKGs), and all other procedures that do not require my specific informed consent. I understand that as a patient, I am under the direct and indirect care of licensed physicians that are on the medical staff of the hospital. I further understand that the physicians who provide treatment to me while I am here are not employees of the hospital. I realize that, in an effort to provide proper treatment for me, my physician may consult with other physicians on the medical staff that I may not meet, such as a radiologist, pathologist, anesthesiologist, etc**. I realize these physicians will likely produce a bill for services that is separate from the hospital's bill.** I agree and acknowledge that the hospital and its employees, agents and representatives are not liable for the actions or omissions of, or for carrying out the instructions given by, the physicians who treat me while I am in the hospital. **I am aware that some physicians may not participate in the health plan or payment program that pays for my care and, thus, I may be subject to additional charges.** In addition, I understand that the hospital has educational affiliations with medical schools and other education institutions, and I agree to medical resident and student participation in my care, under supervision as appropriate.

Consent to Photographs/Videotapes/Recordings

I authorize the hospital to obtain photographs, videotapes and/or recordings of me for identification, diagnosis, treatment, and internal health care operations. I understand I may revoke this consent up until a reasonable time before such images/recordings are used. Any further use and/or disclosure of these images/recordings is restricted to those purposes I consent to at a later time.

Valuables

I understand and agree that the hospital assumes no liability for any loss or damage to any money, jewelry, documents, furs, or other articles brought by or for me to the hospital. I understand the hospital maintains a safe for the storage of valuables and other articles during inpatient hospitalizations that I may utilize upon request. No employee or other person is authorized to suggest or recommend storage of such articles by any other means.

Disclosure of Information for Payment and Health Care Operations

I understand that the hospital is authorized by law to use and disclose my general patient health care records for payment and health care operations without my authorization. However, I recognize that the hospital needs my authorization to disclose, if applicable, my HIV test results and treatment records related to mental health, developmental disabilities or alcohol and drug abuse (collectively, "Sensitive Information") for payment and health care operations. Accordingly, I hereby authorize the hospital to disclose my Sensitive Information, as applicable, to Aurora Health Care billing personnel, my health plan and any other identified payers as necessary for the purpose of billing, collection or payment of claims. I further authorize the hospital to disclose my Sensitive Information to other Aurora Health Care affiliated entities for health care operations. This authorization will remain in effect for as long as my Sensitive Information is needed for these purposes. I am aware that I may revoke my authorization in writing at any time except to the extent the hospital has already acted in reliance upon the authorization. In addition, I understand that I have a right, upon request, to inspect and receive a copy of all such information being disclosed. **Please refer to the hospital's Notice of Privacy Practices for a detailed description of how the hospital may use and/or disclose your health information.**

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Assignment of Insurance Benefits/Charges/Refunds

I hereby authorize and assign payment directly to the hospital for such health expense insurance and other benefits and payments otherwise payable to me, but not to exceed the hospital's regular charge for the hospital services it renders. I understand that I am financially responsible to the hospital and the independent physicians who render services to me. I agree to pay the hospital the hospital's regular charges as set forth in its then current chargemaster and pay all charges of physicians and others, including co-insurance and deductibles, not covered by my insurance, subject to applicable Medicare and Medicaid advance notice requirements. To the fullest extent permitted by law, I authorize the hospital to transfer payments made by, or on my behalf, and otherwise refundable to me, to other Aurora Health Care accounts for which I am responsible. The assignment in this paragraph is valid until my accounts are paid in full.

Notice of Privacy Practices, Payment Policy and Patient Rights

I acknowledge that the hospital (an affiliate of Aurora Health Care, Inc.) has provided me a copy of its Notice of Privacy Practices, Payment Policy and Patient Rights. I understand the Notices describe the hospital's privacy practices regarding the use and/or disclosure of health information, the hospital's payment policy regarding charges for hospital services, collection, charity care and payment assistance programs, and other patient rights. I may not have elected to retain these brochures.

Home Health, Hospice and Durable Medical Equipment

Even at the time of admission/registration, it is important to start considering and planning for post-discharge care. I understand that I have the freedom to choose and the right to select my provider/supplier for post-discharge care and equipment I may need. I am aware that for home health care and hospice services and durable medical equipment after discharge, the hospital will generally use Aurora at Home (an affiliate of the hospital) or another affiliate of the hospital, unless I select a different provider/supplier. I understand that I will receive a list of other available home care agencies prior to my discharge from the hospital if it is determined that post hospital services are required for my care.

My signature below certifies that I have read and understand this Treatment Agreement and I have provided the hospital accurate information to the best of my knowledge including, without limitation, information regarding financial assistance.

Date	Time	Signature of Patient	
Date	Time	Signature of Legally Authorized Agent(s)	Relationship to patient

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

Date: _____ Time: _____ Interpreter Name: _____ ID #: _____

For Aurora Personnel Use Only

Brochures Offered:

Notice of Privacy Practices: ☐ Accepted ☐ Declined
Patient Rights: ☐ Accepted ☐ Declined
Payment Policy: ☐ Accepted ☐ Declined
No Surprise Billing Disclosure: ☐ Accepted ☐ Declined

Date: _____ Time: _____ Signature: _____