MORRIS HOSPITAL and HEALTHCARE CENTERS
CONSENT FORM and AGREEMENT
AND INDEPENDENT CONTRACTOR DISCLOSURE

1. CONSENT TO TREATMENT **Acct#: _____**

I, _____, believing I have a condition requiring medical care, hereby voluntarily consent to such care at Morris Hospital & Healthcare Centers("MHHC"). I consent to diagnosis, medical care and treatment that I have agreed to receive and that is considered necessary or recommended by my physicians(s) and other healthcare providers (collectively, "practitioners").

2. GENERAL CONSENTS and ACKNOWLEDGEMENTS:

A. I understand that the practice of medicine and surgery is not an exact science. I acknowledge no guarantees have been made to me as to the diagnosis or result of examination or treatment at MHHC. If I am pregnant, I understand that all the provisions in this agreement apply to my newborn child/children for their medical care and treatment.

B. **Independent Contractor Disclosure: I understand the following regarding the practitioners involved in my care:**

i. Employed practitioners:– S. Ahmed, F. Aijaz, M. Ali, H. Amin, S. Analytis, P. Analytis, D. Anjum, R. Yahaira Aramburo, M. Bialas, I. Best, A. Blough, A. Bohland, S.Bojak, J. Bolden, C. Brozovich, E. Cacello, L. Carls, N. Chalisa, S. Cheng, A. Chen, S. Ciechna, R. Colby, C. Comfort, M. Connolly, S. Davis, R. Duke, A. Eldib, M. Fitzgibbon, L. Fochesatto, S. Franzetti, J. Frye, M. Ghanim, J. Greggain, I. Habib, K. Haque, H. Hedayati, S. Henline, M. Hill, D. Howd, L. Jakubonis, S.Johnson, J. Jones, C. Kao, M. Kryza, B. Lawton, C. Lopez, M. Menz, R. Meyer, I. Mezo, C. Miller, H. Miller, L. Moy, V. Ochoa, D. Olsen, M. Passerman, K. Pearson, O. Peplos, P. Perona, S. Pettry-Soto, A. Piper, S. Pruss, F. Rahman, D. Raval, K. Rezin, P. Roumeliotis, M. Saed, A. Saeed, B. Said, S. Schiazza, N. Seplak, L. Setrini-Best, A. Spoon, A. Staker, T. Stuedemann, K. Suste, J. Tanzi, J. Thomas, K. Tiwari, A. Todd, D. Toussaint, S. Treacy, K. Ulivi, L.Verchimak, D. Vermillion, R. Williams and D. Zuelke are employed by MHHC.

ii. Non-Employed practitioners- all practitioners , other than those listed in B.i, including those who provide remote monitoring during surgeries or provide "virtual" services, are not employees or agents of MHHC. Instead, these are independent practitioners who have been permitted to use MHHC facilities and to exercise their independent medical judgement in the care and treatment of their patients.

iii. I acknowledge that the employment status of the practitioners who treat me is not relevant to my selection of MHHC for my medical care and treatment. MHHC does not control or direct any practitioner's care of his or her patients. Further, I understand the practitioners practice independent medical judgement in my care and treatment.

****I acknoweledge that I have read and understand the Independent Contractor Disclosure and that any questions have been answered to my satisfaction. Pt/legal representative Initials _____**

C. I understand that I have a right to express a concern or grievance regarding any quality of care issue either informally or formally through the patient grievance mechanism established by MHHC.

D. I agree that all telephone numbers and email addresses I provide to MHHC may be used by MHHC or those acting on its behalf to communicate with me by telephone (including cell phone), text, or any automated or prerecorded messages.

E. I acknowledge and agree that money, jewelry and other valuables should not be brought into any MHHC facility; but if I do bring them into a MHHC facility, I agree they should be deposited with the facility's cashier or sent home by me with a responsible person. I agree that I will not hold MHHC liable for the loss or damage to any money, jewelry, glasses dentures, documents, fur coats, or other articles, goods or property of any kind that I bring into the facility. I agree to inform the nursing staff of any valuables in my possession.

3. MY HEALTH INFORMATION

A. I authorize MHHC to retain, preserve and use for scientific or teaching purposes or to dispose of any specimen or tissue taken from my body during my hospitalization.

B. In the event I am (or my child is)transferred/referred to another health care facility, I authorize MHHC to release information and/or copies of my medical record or portions thereof to such other health care facility and/or practitioner in the event of such transfer/referral. I further authorize the facility and any practitioners to which I am (or my child is)transferred/referred to provide information to MHHC upon request regarding the care, condition and treatment of myself (and/or my child).

C. I authorize the use of my medical records for quality assurance and/or risk management purposes. I further authorize any practitioners involved in my care to provide information to MHHC upon request concerning my care, condition, and treatment.

D. In the event a practitioner or other individual involved in my care sustains exposure to my blood or body fluids, I understand MHHC may test my blood for infectious disease of any nature and description.

E. I agree that MHHC can use and disclose my health information for treatment payment and operations purposes, and as otherwise described in the MHHC Notice of Privacy Practices.

If I am an obstetrical patient, I understand that MHHC may use and release my health information for the care and treatment of my newborn child/children, for related payment and MHHC operations. I understand that my health information will be included in my newborn child/children's records.

4. FINANCIAL CONSENT AND ACKNOWLEDGEMENTS:

A. I authorize MHHC to release and/or send any medical information deemed by it to be necessary for the processing and payment of my bills for services rendered by MHHC and its employed or contracted practitioners for which it is authorized to bill to any insurance company or other third party payor who is or may be responsible for paying any part of my medical treatment.

B. I understand this information may include the diagnosis of and treatment for mental illness, substance abuse disorder, human immunodeficiency virus, and genetic testing.

C. I understand that, whether a consent is signed as patient, agent or as guarantor, I am directly responsible and will pay for the services rendered by MHHC and those for whom it is authorized to bill and is not paid by insurance.

D. I acknowledge that I may receive a separate bill for services from each of the independent practitioners providing services at MHHC for the

services provided. I am solely responsible for the payment of any bills received from these independent practitioners. These independent practitioners may or may not participate in managed care contracts and it is my responsibility to confirm their participation in any particular managed care plan or insurance.

E. I understand this authorization is furnished to enable MHHC, the practitioners for whom it is authorized to bill, and also independent practitioners who bill on their own behalf, and me, to obtain or attempt to obtain proceeds, benefits or amounts due to me or to members of my family from insurance companies or third party payors due to my treatment and hospitalization. In consideration of MHHC's cooperation in securing or attempting to secure said amount on my behalf, I release MHHC, its agents, servants, employees and attorneys from all responsibilities and/or liabilities incidental to their release of my medical records and other information.

F. I further authorize MHHC to release and/or send copies of my records or portions thereof to my practitioners and to practitioners on MHHC medical staff or those of other hospitals who were consulted in regard to my treatment, for the purpose of billing and collection amounts due to them for services rendered. This release includes the results of any blood test performed to determine the presence of the Human Immunodeficiency Virus (causative agent of AIDS).

G. In the event I am entitled to benefits arising out of any policy insuring me, I hereby assign those benefits to MHHC for application on my bill.

H. MHHC may obtain a consumer report on me from any Consumer Reporting Agency. Should my account be referred for collection, I (patient, agent, or guarantor) shall pay all reasonable costs of collection including but not limited to, attorneys' fees incurred because of any suit or claim that may be filed or asserted in connection therewith.

I. If I do not have health insurance or have difficulty paying my MHHC bill, MHHC provides financial assistance options, including free care, discounted care or interest-free payment plans. Information about MHHC's financial assistance program, qualification criteria and whether or not my practitioner or other practitioners offer financial assistance is available from MHHC patient accounts department.

5. OTHER ACKNOWLEDGEMENTS AND CONSENTS

A. Important Message from Medicare: my signature acknowledges my receipts from MHHC of the Important Message from Medicare.

B. I have been informed of my patient rights and responsibilities. **Pt/legal representative Initials _____**

C. By signing below, I acknowledge that I have received a copy of MHHC's Notice of Privacy Practices.

D. I understand that MHHC's authorized nursing and allied health students accompany and sometimes participate with practitioners and MHHC staff in the delivery of, as well as the observation of care.

E. I understand that I may cancel or revoke any authorization or consent I have given by notifying MHHC's Privacy Officer in writing at any time. I can reach the Privacy Officer by writing to Morris Hospital, 150 W. High St. Morris, IL 60450, Attn. Privacy Officer or by fax at 815-942-3203.

F. I certify I have read the Consent Form and Agreement and I am the patient or I am duly authorized to execute this acknowledgement on behalf of the patient. I accept the terms of this agreement.

G. This consent form and agreement will expire upon the earlier of the cessation of treatment at MHHC or one (1) year from the date hereof. Please note: Healthcare Center consents are valid unless revoked.

Patient, legal representative Signature: **DATE:** **TIME:**

X_____ _____ _____

_____ _____

Relationship of Above to Patient Witness Signature

DD_____ **Interpreter (if applicable)_____**