Lurie Children's Primary Care
Town & Country Pediatrics

Ambulatory/OPS Consent to Examination and Treatment

5 2 6 7

Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

CONSENT TO EXAMINATION AND TREATMENT

I hereby give my consent for the above patient to receive medical and/or dental examinations, treatment, and diagnostic procedures at Ann & Robert H. Lurie Children's Hospital of Chicago or at one of its affiliated locations (collectively, "Lurie Children's"). Such examinations and treatments may include, but shall not be limited to, any operation or operations or diagnostic procedures including the use of anesthesia, and the administration of blood, deemed advisable by the medical or dental staff in the exercise of their professional judgment. I understand that this consent authorizes any reasonable medical action taken for any purpose during the time the patient remains registered with Lurie Children's. I understand that I may opt out of HIV testing and I need to inform my provider should I wish to opt out of such testing. I acknowledge that services may be provided by one or more of the following affiliated Providers (each of which may bill me separately): Ann & Robert H. Lurie Children's Hospital of Chicago, Pediatric Faculty Foundation, Inc., Children's Surgical Foundation, Inc., Pediatric Anesthesia Associates, Ltd., Lurie Children's Medical Group, LLC, Lurie Children's Primary Care, LLC, Almost Home Kids, and their physicians, nurses and other personnel. I understand that Lurie Children's operates and participates in a health information exchange (the "Exchange") that facilitates the electronic sharing of medical and other individually identifiable patient health information among all health care providers that participate in the Exchange, including Lurie Children's affiliated Providers. I understand that medical information available to Exchange participants may include sensitive information relating to HIV/AIDS; Behavioral or mental health records; sexually transmitted diseases; Pregnancy; Birth control; Drug/alcohol treatment records; Genetic information; Information about sexual assault/abuse; Information about child abuse and neglect; and Domestic abuse of an adult with a disability.

I understand that representatives from various manufacturers or suppliers of medical equipment and/or devices may be present while I am/my child is receiving medical care and treatment by providers at Lurie Children's. The presence of these individuals is to assist the physicians and other health care practitioners in my/my child's care.

I hereby authorize Lurie Children's and its medical staff, residents, fellows and medical, nursing and other allied health students to take photographs, videos, digital and other images and audio-recordings of me/my child for treatment, education and research purposes. I understand that such images may be disclosed within Lurie Children's for these purposes without additional authorization by me/my child. I also understand that Lurie Children's may utilize such images externally for these purposes without additional authorization by me/my child, provided that me/my child's identity will not be revealed from the image or other text. I agree that all reproduction and all copyrights associated with the above-described information and media are and shall remain the property of Lurie Children's, its successors and/or assigns.

ASSIGNMENT OF INSURANCE BENEFITS & GUARANTEE OF PAYMENT

In consideration of any medical care provided to the above named patient, I hereby assign, transfer and set over to Lurie Children's and the Providers listed above all my rights, title and interest to any and all medical reimbursement under my insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by Lurie Children's and the Providers listed above.

I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance at the current rates established by Lurie Children's and the Providers listed above for all services rendered to the above named patient from date of admission until discharge. I hereby further agree that I shall be responsible for any expense of Lurie Children's and the Providers listed above in collecting the amounts guaranteed hereby, including all court costs, reasonable attorneys' fees and all other collection expenses.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION FOR FACILITY AND PHYSICIAN/SURGEON PAYMENT, COLLECTIONS, MARKETING AND FUNDRAISING

I hereby authorize Lurie Children's and the Providers listed above to release all medical information that may be necessary for the payment on my behalf for the health care services rendered to the above named patient. This authorization may be revoked in writing at any time except to the extent that the actions have been taken in reliance thereon. I understand that I will be financially responsible for charges incurred for treatment if revocation or refusal to authorize the disclosure of copies of medical records or medical information results in payment denial of the insurance claim. I understand that the telephone number(s) and email address(es) I provide may be utilized to contact me for marketing, fundraising, payment and collection purposes

This consent to examination and treatment, assignment of benefits, guarantee of payment and authorization for disclosure of information contained herein shall be effective beginning on the date written below and shall remain in force for a period of one (1) year from such date, or until revoked, invalidated, or updated/replaced or where Lurie Children's otherwise determines another such consent form is required.

Are you willing to be contacted about Clinical Research that may pertain to your child's diagnosis? YES ☐ NO ☐

PATIENT'S NAME _____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE _____

RELATIONSHIP _____ DATE_____ TIME _____

WITNESS _____ DATE _____ TIME _____

INTERPRETER (as applicable) _____ DATE _____ TIME _____