



### **UNDERSTANDING OF GENERAL CONSENT**

This General Consent is about your care at the Shirley Ryan AbilityLab. Please sign below to show that you have read it (or it has been translated for you in a language you understand) and you agree to the statements in it.

### **CHANGES TO INSURANCE COVERAGE**

If there are any changes to your insurance coverage, please notify Shirley Ryan AbilityLab immediately by calling (312) 238-6039.

### **FINANCIAL ASSISTANCE**

You may be eligible for financial assistance. If you would like additional information or a written summary of Shirley Ryan AbilityLab's Charity Care Financial Assistance Program, please notify a Shirley Ryan AbilityLab staff member or call 312-238-6039.

### **RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, you also acknowledge having received a copy of the Shirley Ryan AbilityLab Notice of Privacy Practices.

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Signature of Patient or Legally Authorized Representative

Date of Signature

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Witness Signature

Date of Signature

## GENERAL CONSENT

### CONSENT FOR DIAGNOSIS, CARE AND TREATMENT

I agree to receive care at the Shirley Ryan AbilityLab I may receive care from my attending doctor or from different health care providers at Shirley Ryan AbilityLab, such as other doctors or other health care professionals. My care may include examination, diagnosis, treatment, and procedures. I understand that Shirley Ryan AbilityLab is a teaching hospital. This means that I may receive care from providers who are in training, such as doctors, nurses, and therapists. No one has guaranteed the results of my care. I can ask questions to help me understand my care. I can refuse care my providers suggest. However, there are consequences if I refuse this care. For example, I may not receive care that I medically need.

### RESPONSIBILITY FOR PAYMENT

I may have health insurance that covers the costs of services I receive at Shirley Ryan AbilityLab which may include health care professional fees, and the costs of facilities or supplies used in my care or in other services provided to me. For instance, I may have health insurance through a private insurer, Medicare, Medicaid, worker's compensation, auto liability, or another government or other insurance program. Even with my insurance, I may have to pay for some of the services I receive. For instance, my insurance will not pay my deductible or my co-payment. My insurance also will not pay for services it does not cover. My insurance may not pay for services unless it or its representative receives my health information. As explained further below, my insurance may not pay for services that have not been authorized in advance. If Shirley Ryan AbilityLab requires my permission to provide this information, and I do not provide it, my insurance may not pay for the services I receive. Shirley Ryan AbilityLab or my doctor will bill me for the amounts that my insurance will not pay. I agree to pay those amounts.

I will pay for the services I receive that are not covered by my insurance. I may qualify for financial assistance. I can contact Shirley Ryan AbilityLab's Patient Financial Services at (312) 238-6039 for more information.

### INSURANCE PRE-CERTIFICATION

If I have insurance, I may need to contact my insurer or my primary care doctor before I receive certain kinds of services. I am responsible for contacting my insurer or my primary care doctor before I receive these services. If I do not call, I may have to personally pay for more (or even all) of the services I receive. If I am not sure whether to contact my insurer or my primary care doctor, I will ask.

### ASSIGNMENT OF BENEFITS / BILLING / COVERAGE

I allow Shirley Ryan AbilityLab and my doctor to bill my insurance for the services I receive. I give up my right to receive payment from my insurance for these services. I agree that my insurer can pay all benefits directly to Shirley Ryan AbilityLab or to my doctor. I allow Shirley Ryan AbilityLab to complete claim forms on my behalf. I will cooperate with Shirley Ryan AbilityLab in this effort, at its request. If Shirley Ryan AbilityLab needs information from me for my insurance to pay my bill, I will give correct information.

## FAIR PATIENT BILLING ACT NOTICE

I may receive separate bills for services provided by health care providers affiliated with Shirley Ryan AbilityLab. If my doctor provides services, I may get two bills – one for the doctor’s services and one from the hospital facility. The Patient Notification Regarding Billing has more information about these two bills. Some staff members may not be participating providers in the same insurance plan and networks as Shirley Ryan AbilityLab. I may have a greater financial responsibility for services provided by health care providers at Shirley Ryan AbilityLab who are not under contract with my insurer. Any questions regarding coverage or benefit levels should be directed to my insurer and my certificate of coverage.

## BEHAVIOR

As a patient, I will do my best to participate in my care plan. I will follow the care plan set out by my doctor and care team. I will treat other patients, visitors, and Shirley Ryan AbilityLab staff, with respect. Shirley Ryan AbilityLab does not allow verbal or physical abuse. If I am an inpatient, I will wear my identification band at all times as requested by my care team. Shirley Ryan AbilityLab does not allow disruptive behavior. Shirley Ryan AbilityLab does not allow illegal drugs, alcohol, firearms, or other weapons. Shirley Ryan AbilityLab does not allow taking pictures or making other recordings of patients, visitors (other than my own), participants, or providers, without their written permission. Anyone who violates these rules may be required to leave Shirley Ryan AbilityLab immediately. If my visitors violate these rules, I may be required to leave Shirley Ryan AbilityLab immediately.

## PERSONAL PROPERTY

I should not bring property to Shirley Ryan AbilityLab that I would miss if it were lost or stolen. Examples include electronic devices, glasses, jewelry, dentures, contact lenses, hearing aids, cash, checks, credit cards, or valuable papers. Property may be lost, damaged, or stolen. I am responsible for all my property and my visitors’ property. **Shirley Ryan AbilityLab is not responsible for my or my visitors’ property.**

## CONSENT FOR PHOTOGRAPH

Shirley Ryan AbilityLab can allow my providers or others it identifies to photograph or otherwise record my visitors and me. Photographs or recordings will be made in connection with the services I receive and may be used to help identify me or for safety reasons. Photographs and recordings may also be used for appropriate research and educational purposes. Shirley Ryan AbilityLab may include a photo or other recording of me in my medical record.

## OUTINGS AND ACTIVITIES

Rehabilitation may include community outings or other activities. These activities can be helpful to patients. Activities are supervised and planned in accordance with a patient's mental and physical ability. However, they can present risks. The activities may require increased physical activity. I allow Shirley Ryan AbilityLab to include such activities in my care. If the activity requires travel, I permit Shirley Ryan AbilityLab to provide transportation. I release Shirley Ryan AbilityLab from responsibility for any injury or other harm that may happen during such activities. However, this release does not extend to injury or other harm that results from gross negligence or willful misconduct of Shirley Ryan AbilityLab or its employees.

**NO CHANGES TO THE GENERAL CONSENT**

I am signing this consent based upon my own decision and choice without undue influence by anyone else. This consent is effective for as long as I receive care at Shirley Ryan AbilityLab, and at least one year from the date I sign it or until I sign a new consent. Shirley Ryan AbilityLab will not be bound by any changes I make to the General Consent.