Patient Label Goes Here

Shirley Ryan Abilitylab

UNDERSTANDING OF GENERAL CONSENT

This General Consent is about your care at 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.

GENERAL CONSENT

CONSENT FOR DIAGNOSIS, CARE AND TREATMENT

I agree to receive care at 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, including but not limited to health care professional fees, charges for facilities or supplies used in my care, or charges for other services provided to me. For instance, I may have health insurance through a private insurer, Medicare, Medicaid, workers' compensation insurance, auto liability insurance, or another government or other commercial 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-AUTHORIZATION

If I have insurance, I may need to contact my insurer or my primary care doctor before I receive certain kinds of services. If I do not call, I may have to personally pay for more (or even all) of the services I receive. If I have any questions regarding my coverage, I will contact my insurer.

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 provider 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 also allow Shirley Ryan AbilityLab to take any steps necessary to receive payment from my insurance provider for services I have received, including filing appeals with the Illinois Department of Insurance on my behalf, when necessary, if my insurance company denies payment for services I received. I will cooperate with Shirley Ryan AbilityLab in this effort, at its request. If Shirley Ryan AbilityLab needs information from me for my insurance provider 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. Services provided by providers who do not participate in my insurance plan or network are known as "out-of-network services." I may have a greater financial responsibility for out-of-network services. If Shirley Ryan AbilityLab believes I will receive out-of-network services that may result in a greater financial responsibility for me, I will be given additional information about the additional cost of services. If I have questions regarding my insurance coverage or benefits, I should consult my insurance certificate of coverage or contact my insurer.

PATIENT AND VISITOR 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 tolerate disruptive, offensive, threatening, violent, or aggressive behavior toward patients, visitors, or staff. This includes harassing, discriminatory, and/or derogatory statements and actions made to anyone (i.e., other patients, employees, visitors, etc.). 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 illegal drugs, cannabis/marijuana or any derivative containing 0.3% or more THC, alcohol, cigarettes, vape pens, firearms, or other weapons at the hospital or any of its off-site locations. 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.

Patient's Initials _____

Anyone who violates these rules may be required to leave Shirley Ryan AbilityLab immediately. If my visitors violate these rules, they may be required to leave Shirley Ryan AbilityLab immediately, and it could also result in my discharge from care.

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. Shirley Ryan AbilityLab discourages me from having any cash on the premises. Property may be lost, damaged, or stolen. I am solely responsible for all of my property and my visitors' property. **Shirley Ryan AbilityLab is not responsible for my property or my visitors' property.**

CONSENT TO PHOTOGRAPH

In connection with the services I receive, Shirley Ryan AbilityLab can allow my providers or others it identifies to photograph or otherwise record me. The photographs and/or recordings may be included in my medical record and used to help identify me for safety reasons or for appropriate research and educational purposes. Unless I give permission, Shirley Ryan AbilityLab will not share such photographs or recordings with people outside of Shirley Ryan AbilityLab.

CONSENT TO RECORD MEDICAL APPOINTMENTS

With my permission, Shirley Ryan AbilityLab may use a device called a Virtual Scribe to record and transcribe my conversation with my healthcare providers during my medical appointments. These recordings will help my provider document my visit, and will be destroyed shortly after my appointment. I understand that these recordings are not part of my medical record and copies will not be made available to me. Shirley Ryan AbilityLab will not use a Virtual Scribe to record my conversations without my express permission. I am not required to agree to the use of a Virtual Scribe, and my care at Shirley Ryan AbilityLab will not be impacted if I do not give permission for the use of a Virtual Scribe.

SHARING OF INFORMATION

Shirley Ryan AbilityLab may share my protected health information as allowed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") for purposes of treatment, payment, and Shirley Ryan AbilityLab operations. Under HIPAA, Shirley Ryan AbilityLab may share my protected health information with my healthcare providers at other locations for purposes including treatment and care coordination related to my care here. Shirley Ryan AbilityLab participates in the Cerner CommonWell health information exchange, which allows my treating providers at other locations who also user Cerner CommonWell to use a secure electronic system to review my Shirley Ryan AbilityLab medical records when the records relate to care and treatment I am receiving from those providers. Shirley Ryan AbilityLab may also share my protected health information through a state-designated health information exchange. Only providers that I have an established relationship with, and my insurance company, may have access to my records through the health information exchanges. I may opt out of the health information exchanges by submitting a Written Revocation to the Shirley Ryan AbilityLab Privacy Officer. Written Revocation forms are available and can be requested from the Privacy Officer by e-mailing privacyofficer@sralab.org. Shirley Ryan AbilityLab's Notice of Privacy Practices includes additional information about how my health information may be used in accordance with HIPAA. A copy of the Notice of Privacy Practices is available on the Shirley Ryan AbilityLab website and upon request.

Patient's Initials _____

OUTINGS AND ACTIVITIES

Rehabilitation may include community outings or other activities that may occur off the patient's unit or outside Shirley Ryan AbilityLab. These activities can be helpful to patients. Activities may or may not be supervised, but are approved and planned in accordance with a patient's mental and physical ability. However, such activities can present risks. 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. I also release Shirley Ryan AbilityLab from responsibility for any injury or harm that may happen if I leave the unit, floor, or building without permission or outside the scope of the permission. 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 have read, understand, and agree to this General Consent. I have been given the opportunity to ask questions, and any questions I asked have been answered. 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 or until I sign a new consent. Shirley Ryan AbilityLab will not be bound by any changes I make to the General Consent.

Signatures on following page

Patient's Initials _____

PATIENT SIGNATURE DATE

LEGALLY AUTHORIZED REPRESENTATIVE DATE
(if patient lacks decision-making capacity, or is a minor who is not emancipated or who is not otherwise deemed by law to be able to provide consent)

- Relationship of Legally Authorized Representative to Patient: _____

FOR USE WITH TELEPHONE AND VERBAL CONSENTS

STAFF SIGNATURE (documenting verbal consent of Patient) DATE

- To be used when Patient has decision-making capacity but is physically unable to sign.

STAFF SIGNATURE (documenting telephone consent of Legally Authorized Representative) DATE

- To be used when Patient lacks decision-making capacity and Legally Authorized Representative cannot be present to sign at admission.

WITNESS SIGNATURE (To be used when staff obtain verbal/telephone consent)

WITNESS TITLE DATE TIME