General Consent & Authorization Form

Your privacy is important. For opt out options, please ask registration. We cannot accept any other changes to this form.

CONSENT TO RELEASE OF INFORMATION

For Treatment: I permit Essentia Health and its agents to:

- share my medical information* with other healthcare professionals, facilities, and anyone else Essentia Health believes to be involved in my care, treatment, case management, discharge planning and related services.
- share my information with a health information exchange, record locator service or patient information service. My information may be shared with and accessed by other health care providers and entities for treatment, payment, and the health care operations of those organizations.
- access and/or seek health information about me and the location of my health records through a record locater service or patient information service.
- access my current prescription history of controlled substances in any state database, such as the Minnesota Prescription Monitoring Program (PMP), when consent is required under state law.

For Payment: I permit Essentia Health and agents of Essentia Health to:

- share my medical information* and account records with my health plans and payers, their agents and others as needed for payment purposes (such as eligibility and coverage determinations, billing, processing claims, coordinating benefits and utilization review) and as otherwise required by my health plan and other payers.
- share my medical information* with suppliers of medical equipment, special transportation, or other health services so they can request payment from my insurance or other payer**.
- share my medical information* with my employer or potential employer for only those services provided at Essentia Health where my employer or potential employer agrees to pay for the services.

For Health Care Operations: I permit Essentia Health and approved agents (including Business Associates) of Essentia Health to:

- share my medical information* with others (where consent is required) to improve the quality of my care and experience, and to manage its business operations. This includes sharing my information with accrediting and quality organizations, regulatory agencies, and public health agencies that are responsible for licensing and accreditation, fraud investigation, care management, immunization tracking, public health reporting, drug and device defects or recalls, and quality evaluation.
- share my medical information* with organ donor organizations to assist donations.
- disclose my presence as a hospital patient. This allows me to have visitors, phone calls and mail. If I do not want others to know I am in the hospital, I will tell a staff member when I register.
- disclose my presence and religious preference to Community Faith Leaders or Clergy of my denomination.
- reveal my presence to foundations that support Essentia Health and its mission.

Health Plan Information: I permit my health insurance plan to release to Essentia Health my protected health information about services I have received from Essentia Health and other care providers. Essentia Health may use this to treat me, manage and coordinate my care, and for case management, payment, accreditation, and quality review.

Family Guarantor Billing: If I have agreed to take part in Family Guarantor Billing, I agree that my bill can be combined into one statement that covers my current spouse and minor children with the same mailing address. The statement will be sent to the guarantor listed on the account. The combined bill will include patient name, the date of service, the location of service, a summary of the services received (including type or name of diagnostic tests) and the amount due. I permit Essentia Health to discuss issues of billing or payment with an adult family member listed on my guarantor account**.** That person must give my name, address, date of birth, and my Essentia Health account number(s) as well as his or her own name and address.

Telehealth: I consent to treatment via telehealth. I understand that Essentia Health may use third party, web-based video conferencing vendors to aid real-time treatment sessions with my health care provider and electronically transmit my health information. In rare cases, the information transmitted may be of poor quality. If the equipment is not working, there could be delays in evaluation and treatment. Telehealth appointments are not appropriate when seeking emergency treatment, call 911.

AUTHORIZATION TO ASSIGN BENEFITS

Insurance, assignments of benefits and guarantee of account:

- I agree that payments approved by payers** may be paid directly to Essentia Health on my behalf for any services and/or treatment I received from an Essentia Health provider and/or in an Essentia Health facility. I permit any holder of medical or other information about me to release to payers** and their agents any information needed to determine these benefits or benefits for related services. I understand that I must meet the requirements of my insurance policies.
- I agree to pay any charges not covered by insurance, government programs (including Medical Assistance and Medicare), or other funds. I agree to pay reasonable attorney fees and all costs of collection if my account is turned over to an attorney or collection agency. I understand that it is my responsibility alone to negotiate payment of a claim that is disputed by the payer**.
- For Medicare Patients only: I approve Essentia Health to use my 60 lifetime reserve days as needed after my regular Medicare Benefits expire. I understand if reserve benefits are used, there will be co-insurance due. Once used, they are permanently reduced by the number of days used.

SERVICE TERMS & MISCELLANEOUS

A copy of the Patient Bill of Rights, information on Healthcare Directives, and information about how to file a complaint has been offered to me.

I agree that Essentia Health, its affiliates and agents, may use an automated telephone dialing system to make phone calls or send text messages to my home phone and cellphone number(s) that I gave to Essentia Health for treatment, appointment reminders, payment, health care operations and other notification purposes. Terms and conditions for text message subscriptions are available on the Essentia Health website under "Privacy and Legal Notices."

I agree that I am responsible for my personal valuables (such as money, jewelry, dentures, hearing aids, and eyeglasses) while a patient at Essentia Health. While a patient, I have been encouraged to send all personal items of value home with relatives or friends. I know that there is a safe to keep my personal valuables. I release Essentia Health from any liability for loss of my personal valuables by theft or negligence by me or any hospital employee.

I understand video surveillance is used for patient safety and treatment purposes. Essentia Health respects patient privacy per video surveillance policies.

If this is my first visit to an Essentia Health location, a copy of the current Notice of Privacy Practices has been offered to me It is available to me via postings in the registration areas and on the website www.essentiahealth.org. I understand that I can ask for a copy of the Notice at any time.

- I understand that this consent ends three (3) years from the date signed except for purposes of payment and sharing with Health Information Exchanges that require expressed revocation.
- I understand that I may take back this permission at any time by notifying Essentia Health in writing. No further release will take place after the date notified.
- I understand that other parties may use or disclose health information received from Essentia Health.
- I understand that I will receive a copy of this form.
- For care provided in Wisconsin, I understand Wisconsin law gives me the right to inspect and receive a copy of behavioral health and chemical dependency information to be disclosed.

By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is unable to sign**, a legally authorized person must sign and date the form.
  State your legal authority and provide legal documentation if not already on file:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney) ☐ Other Legal Representative_____
  Note: If none of these apply and this is a medical emergency, the signer has the following relationship with the patient_____
- **If the patient is 17 years or younger**, the patient's parent or legal guardian must sign and date this form, unless an exception exists under state or federal law. State your relationship:
  ☐ Parent ☐ Legal Guardian (provide legal documentation if not already on file)
- **If the patient is deceased**, a legally authorized person must sign and date the form.
  Indicate your legal authority:
  ☐ Surviving Spouse ☐ Surviving Parent ☐ Other Legal Representative (provide legal documentation if not already on file) _____

_____ _____ _____ _____

Signature Date Signed Time Printed Name of the Person Signing *(If not Patient)*

_____

Witness (signature by mark must be witnessed)

* Medical information includes, but is not limited to, information related to behavioral health, sickle cell anemia, HIV or AIDS, communicable diseases, genetic testing, and alcohol and chemical dependency information if such exists.

** Payer includes, but is not limited to, Medicare, Medicaid, Medigap, personal or liability insurance and/or any other funds.

_____

Patient Name and Medical Record Number or Patient Label

You may opt out of the sections below, however, you cannot opt out of sharing information that Essentia Health is required to by law or contract. To opt out of a section, write your initials in the blank in front of that section. No other changes to this form will be accepted.

Opt Outs 1a and 1b: Share my information with a health information exchange, record locator service or patient information service. My information may be shared with and accessed by other health care providers and entities for treatment, payment, and the health care operations of those organizations. Please check which option you prefer:

_____	1a. I allow outside agencies to see that I am an Essentia Health patient. However, before they can get any of my medical information* from my medical record, I will be asked to sign a consent form.
_____	1b. I do not want any outside agencies to see that I am an Essentia Health patient. I do not allow them to access my medical information* in my Essentia Health medical record.

_____ Opt Out 2: Access my current prescription history of controlled substances in any state database, such as the Minnesota Prescription Monitoring Program (PMP) database, when consent is required under state law.

_____ Opt Out 3: Share my medical information* and account records with my health plans and payers, their agents and others as needed for payment purposes (such as eligibility and coverage determinations, billing, processing claims, coordinating benefits and utilization review) and as otherwise required by my health plan and other payers. I understand that if I opt out, Essentia will not be able to submit my claims to my insurance and I must pay my entire bill.

_____ Opt Out 4: Share my medical information* with suppliers of medical equipment, special transportation, or other health services so they can request payment from my insurance or other payer**. If I opt out, I understand that Essentia will not be able to submit my claims to my insurance and I must pay my entire bill.

_____ Opt Out 5: Share my medical information* with public health agencies that are responsible for immunization tracking.

_____ Opt Out 6: Disclose my presence and religious preference to Community Faith Leaders or Clergy of my denomination.

_____ Opt Out 7: I agree that payments approved by payers** may be paid directly to Essentia Health on my behalf for any services and/or treatment I received from an Essentia Health provider and/or in an Essentia Health facility. I permit any holder of medical or other information about me to release to payers** and their agents any information needed to determine these benefits or benefits for related services. I understand I must meet the requirements of my insurance policies.

_____ Opt Out 8: For Medicare Patients only: I approve Essentia Health to use my 60 lifetime reserve days as needed after my regular Medicare Benefits expire. I understand if reserve benefits are used, there will be co-insurance due. Once used, they are permanently reduced by the number of days used.

Opt Outs 9a and 9b: I agree that Essentia Health, its affiliates and agents may use an automated telephone dialing system to make phone calls or send text messages to my home phone and cellphone number(s) that I gave to Essentia Health for treatment, appointment reminders, payment, healthcare operations and other notification purposes.

_____	9a. I do not want to receive automated phone calls or text messages regarding my treatment. Examples: appointment reminders, test results, prescription refills, account notifications.
_____	9b. I do not want to receive automated phone calls or text messages related to Essentia Health operations/other notification purposes: Examples: service/satisfaction surveys, recommended appointments.

* Medical information includes, but is not limited to, information related to behavioral health, sickle cell anemia, HIV or AIDS, communicable diseases, genetic testing, and alcohol and chemical dependency information if such exists.

** Payer includes, but is not limited to, Medicare, Medicaid, MediGap, personal or liability insurance and/or any other funds.

Patient Name and Medical Record Number
Or Patient Label

CON.016 Orig. 7/04; Rev. 7/05, 3/07, 11/07, 1/08, 11/08, 1/09, 7/09, 01/11, 04/11, 09/11; 3/12; 01/13; 11/14; 11/21
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Original: Medical Record **Copy**: Patient