General Consent for Service

This consent applies to you (and your baby if you are giving birth), as well as to all medical staff, hospitals and other places listed at the bottom of this page.[1] **Signing this consent means you agree with the statements below.** If you have questions or concerns about this consent, talk to the staff member helping you with this form.

Treatment

I agree to receive medical treatment. I understand that my Medical Team:

- May include medical residents of Fairview Health Services and University of Minnesota Physicians, other care providers and students who work under my Medical Team.
- May collect facts about my health and family health history.
- Will talk with me about my treatment and answer my questions.
- Can't promise exact results from my treatment.
- Will care for me in an emergency[2], even if I have no insurance or cannot pay.

Insurance and payment

- I agree that my Medical Team:
  - May bill my insurance or other payer and I irrevocably assign my rights and benefits under my plan, including administrative and legal remedies under ERISA and other laws and in equity.
  - May bill my insurance or other payer unless I tell my Medical Team not to send a bill.
  - May receive payments directly from my insurance plan or other payer.
  - May share my health and account records with my insurance plan or other payer and their agents as needed. This would be for billing, payment, claims, quality reviews or to answer questions about my care.
- My insurance plan may need to approve certain treatments before I have them (called *prior authorization* or *referral authorization)*. If I don't get pre-approval, my insurance may not pay for treatment(s).
- I will pay for all charges for services **not** paid by a third party (such as an insurance company), even if my insurance card or benefit card reads otherwise.[3]
- If I need help paying for my care, I will ask about my options when I register. I may be asked questions to see if I qualify for help paying my bill.

Health Information

My information will be documented in my electronic health record. My Medical Team can view my history and record and manage my care, no matter which location I visit at M Health Fairview or its affiliates. I agree that my health information[4] may be shared with or requested from:

- My Medical Team. This will help with my care if I visit another location.
- Other medical professionals or agencies, both in and out of the Fairview system, that help with my care or refer me to services. My information may be needed to carry out business operations, quality improvement, licensing, accreditation or for accountable care organizations and networks.

Notice of Privacy Practices: I understand that some uses or sharing of my medical information do not require my consent, while others do. I have seen the *Joint Notice of Privacy Practices*, which explains my right to keep my medical information private. I will ask for a copy if I would like to take it home.

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[1] This consent applies to Fairview Health Services, HealthEast facilities and services, Range Regional Health Services, Grand Itasca Clinic & Hospital, M Health Fairview, and University of Minnesota Physicians.
[2] Defined in the Emergency Medical Treatment and Active Labor Act.
[3] Information on charges, including a listing of current, standard charges, can be found at https://www.fairview.org/billing.
[4] Health records include information about mental and physical health, health care, payment for health care and demographics.

Research: I allow my health records to be used for research. I understand that their use must follow state and federal laws that protect research patients.

☐ If I do NOT agree, I will check this box.

Electronic Health Information Exchange (HIE): I understand that the HIE allows medical care providers to access and securely share my health and medication information electronically without having to ask for printed records. I agree that my Medical Team—and any Medical Teams who treat me in the future—may use or share my information with an HIE or similar database service.

☐ If I do NOT agree, I will check this box.

Consent for payers to share information: I agree that my insurance plan may release (share) my health and account records from other providers with my Medical Team as needed. They may do this to give me better care.

☐ If I do NOT agree, I will check this box.

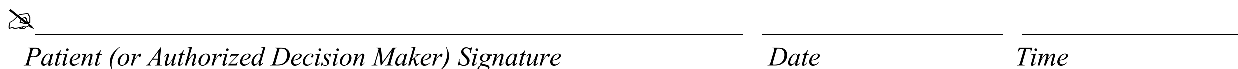
Telephone, email or text messages: I agree that Fairview Health Services and its affiliates may use the contact information I provide to reach me or send me information. Some examples include: appointment and billing reminders, collections, satisfaction surveys and healthcare messages, such as information about new service offerings and preventative care. I understand that I may receive phone calls, autodialed calls, e-mails, text messages and recorded messages. I can opt-out of these messages. I can update my contact information if needed.

Photos and videos: I agree that my Medical Team may take photos or videos of me for treatment or teaching purposes. I will tell my Medical Team if I don't want photos or videos taken of me. I understand that video monitoring is used onsite for clinical, operations and safety reasons. These images are only visible to authorized personnel and are not routinely saved. If images must be saved, it is for an authorized purpose, such as quality improvement. Images are stored confidentially and released only with proper authorization.

Valuables: I understand that I am responsible for my personal belongings and valuables. My Medical Team is not responsible for any loss or damage to my personal items.

Other: I understand that this consent remains in effect until I cancel it in writing. Any actions already taken while my consent was in effect can't be undone. No changes to this form can be accepted.

My signature below shows that **I agree** with this Consent. **I agree to receive medical treatment.**



Patient (or Authorized Decision Maker) Signature *Date* *Time*

Printed Name of Patient or Authorized Decision Maker Relationship to patient (if applicable)

To be filled in by staff, if applicable:

Interpreter Name Date Time

Agency or Employer Language ID# (if video or phone was used)

FIIRO GAAR AH: Hadii aad ku hadasho Soomaali, waaxda luqadaha, qaybta kaalmada adeegyada, waxay idiin hayaan adeeg kharash la'aan ah. So wac 612-273-3780. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-273-3780.
We comply with applicable federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender or gender identity.