CONSENT FOR SERVICE-CHIPPEWA COUNTY-MONTEVIDEO HOSPITAL

This consent applies to all Chippewa County-Montevideo Hospital providers and locations, where I receive care. It applies to me and, if I am pregnant, to any child I give birth to at this location.

Consent for Treatment: I understand that I have a condition that requires diagnosis and treatment. I will have a chance to discuss with my Care Team the treatment that my Care Team believes is needed. The team members who treat me under a doctor's supervision may include medical residents and students. To provide this care, Care Teams may collect information about my health, including genetic information such as family health history. Care Teams will answer my questions about treatment, and I may refuse any recommended treatment. Care Teams cannot promise specific results. If I am seeking care at a hospital and have an emergency medical condition (as defined in the Emergency Medical Treatment and Active Labor Act), Care Teams will provide care to stabilize me, even if I have no insurance or cannot pay.

Release of Information: Care Teams may release my health records (health records include information about mental and physical health, health care, payment for health care and demographic information) to other providers, community health agencies or other external groups for use in my treatment, including care coordination. Care Teams may also share my health records with quality. My records will be stored for as long as policy requires. If I am in the hospital, staff members may tell others where I am, but will not give out my private information. 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.

Prior Authorization: The rules of my insurance plan may require approval before I have certain treatments. If I don't get approval, the plan may not pay for the treatments.

Assignment of Insurance Benefits: Care Teams may bill my insurance and I ask that my insurance payments be made to my care team. Care teams may share my health and account records with payers and their agents as needed for billing, payment and claims. This includes investigations or quality reviews. I will pay for all services not covered or paid by a third party (such as an insurance company). If I need help paying for my care, I will ask about my options when I register. A screening program may be used to see if I can get help paying my bill.

Charges/Estimates: I will not know my total charges until my care is complete. My total may differ from that of other patients, depending on my insurance (or lack of it). I may ask for an estimate of my charges by calling Chippewa County-Montevideo Hospital at 320-269-8877.

Surveys: I may receive a patient satisfaction survey, either by mail, email, or telephone. Completing the survey helps Chippewa County-Montevideo Hospital provide better care. I will still receive medical treatment if I decline the surveys.

Communication: I understand that Care Teams/Business Office may need to call me about my services and accounts. I agree to receive pre-recorded/ artificial voice messages calls and/or use of an automatic dialing device, text messages and/or emails from Care Teams/Business Office, our partners, subcontractors, or any and all other companies that we may have to transfer your account to at any telephone number or email address that you have provided us or that we have otherwise obtained, which could result in charges to you.

Photos/Videos: Care Teams may take photos or videos for medical or teaching purposes. If the photos or videos are used for teaching, my name or other information that would identify me will not be shown.

Valuables: I am responsible for my own valuables. If I am staying in the hospital, I may ask how I can store them safely.

Consent for Payers to Release Information: My insurers may share my health and account records with my Care Team about services I have received from them and from other providers. They may do this as needed to manage or coordinate my care and to improve the quality of that care. If I do not wish to have my insurers release health records as described above, I will check this box ☐.

Use of Health Records in Research: Research leads to new and better ways to diagnose and treat disease. Medical advances depend upon research using medical records. If I allow the use of my information for research, it must be handled as directed by state and federal laws. For example, my identity would be protected in published research results. I agree to let my health records be used for research as described in my Care Teams' Privacy Notice. If I do not agree to this, I will check this box ☐.

Notice of Privacy Practices: I have received my Care Teams' Notice of Privacy Practices. This Notice explains my rights to my medical information, and it describes how that information may be used and disclosed. This is a once in a lifetime consent, so this may not be needed.

Summary: If I have concerns with this consent, I will discuss them with the staff member who is helping me with this form. The authorizations on this form will last until I revoke (withdraw) them in writing. However, any actions already taken while my consent was in effect will remain valid (cannot be undone). If I have questions, I may contact the Chippewa County-Montevideo Hospital Privacy Officer at 320-321-8211.

_____ _____ _____

Patient or authorized decision maker *Relationship to patient* *Date & Time*

Interpreter, if used: _____ *Language/Organization:* _____ *Date & Time:* _____

This form must be signed by the patient (rather than another person) unless the patient lacks mental capacity to make decisions or physical capacity to sign. We comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex.