Patient Sticker Here

IU Health Physicians

# OUTPATIENT GENERAL CONSENT FORM

This consent applies to Indiana University Health Physicians, its agents, associates, as well as providers. In each paragraph IU Health Physicians refers to all IU Health Physicians practices. In each paragraph doctors, independent doctors, residents, fellows, nurse practitioners, and physician assistants will be called providers. I understand that some of the providers who may be involved in my care are not employees of Indiana University Health Physicians.

I agree to let IU Health Physicians, its agents, associates, as well as providers give me medical and surgical care. This includes tests, blood tests, exams, anesthesia, procedures and drugs which are necessary for the diagnosis and treatment of my medical condition according to the judgment of my treating provider.

I agree that IU Health Physicians cannot make any explicit guarantee or promises regarding results or cures.

**Teaching Environment**: I understand IU Health Physicians is part of a teaching environment and at times I may be asked to allow students, residents and fellows to be involved in my care.

My data such as demographics, lab results, biopsy results, diagnoses may be used for research. The research may or may not be related to my health care. My data will be carefully treated so I cannot be identified, except as required by law.

I understand IU Health Physicians has a commitment to research and on occasion, I may be contacted about participation in a research study and that I have the right to opt out from further contact.

**Infectious Disease Testing**: I agree to allow IU Health Physicians to test for infectious diseases including hepatitis and human immunodeficiency virus (HIV) if one of my caregivers is exposed to my blood or body fluid. In reciprocity, if I am exposed to any blood or body fluid during my treatment I can request the source person be tested for such infectious diseases in accordance with Universal Protocol; at no cost to parties being tested. All parties involved will have access to results.

**Release of Information**: I agree to allow my previous health care providers to share my medical records with IU Health Physicians to provide my health care. I agree that, if I am not competent to speak for myself, or if I so request, IU Health Physicians may share my medical information with appropriate family members as minimally necessary to make decisions about my care. I agree that as allowed by law, IU Health Physicians may share my medical records with third-party payors, insurance companies, review agencies, welfare departments, and with third-party data service providers including systems like the Indiana Network for Patient Care (INPC). Patients have the right to opt out, in writing, from this program. This may include records about infectious diseases and drug and alcohol abuse treatment. At any time, I may change my mind about agreeing to this release of information by giving notice to IU Health Physicians in writing.

**Health Insurance Portability and Accountability (HIPAA)**: I acknowledge that I have been offered and/or received the IUHP Notice of Privacy Practices.

**Communications**: I agree to allow the physician practice, its assignees, and contractors to contact me via automated dialer or recorded message on any telephone number provided to IU Health. I understand I may opt out of receiving calls and text messages at any time.

**Assignment of Benefits**: I hereby assign payment otherwise payable to me from Medicare, Medicaid, insurance carriers, employees health benefit plans and other third-party payers (collectively referred to as "Plans") to the physicians and other health care providers who provide services, care or treatment to me. I acknowledge that I am responsible for knowing the limitations of my Plan benefits and agree to be personally responsible for paying the charges billed for services, care or treatment. Should my Plan ultimately deny payment for the services, care and treatment provided to me by the physician practice and its health care providers, I am responsible for paying the billed charges for such items. I acknowledge I am responsible for knowing what insurance coverage I have and for following all insurance policy rules. I know that if I do not pay what I owe, they may send the matter to a collection agency or attorney and I understand and agree to be responsible for all collection costs, including reasonable attorney's fees, court costs, and interest.

**Payment Responsibility**: I am responsible for paying for all the care I receive, and if insurance does not cover all the cost, I must pay the remaining balance. I agree IU Health Physicians may release my medical records as necessary to receive all payments that I am entitled to under insurance policies. I am responsible for knowing what insurance coverage I have and for following insurance policy rules. If I do not pay what I owe IU Health Physicians, they may send the matter to a collection agency, or attorney and I understand and agree to be responsible for reasonable attorney's fees, court costs, costs of collection and interest.

**Referrals:** Your provider may refer you to an out of network provider for health care items or services. An out of network provider is not bound by the payment provisions that apply to health care items or services rendered by a network provider under your health plan. You may contact your health plan before receiving health care items or services rendered by an out of network provider to obtain a list of network providers that may render the health care items or services and for additional assistance.

**Duration of Consent**: I may revoke this consent at any time except to the extent IU Health Physicians has already taken action in reliance on it. If I do not revoke it, this consent will continue for one year.

I agree that I have read this form carefully and agree that everything in this agreement applies to current and future health care services provided by IU Health Physicians.

The language in this General Consent may NOT be altered, crossed out, supplemented, or amended in any way.

| | |
|---|---|
| Signature of Patient/Legal Representative Date | Relationship of Legal Representative to the Patient |
| Print Patient Name Date | Signature Adult Witness Date |