Pinckneyville Community Hospital
Family Medical Center
Leading the way to a healthier tomorrow.

PATIENT CONSENT FORM

INDEPENDENT CONTRACTOR DISCLOSURE

I, (**Print Name**) _____, **Date of Birth** _____am presenting myself or minor dependent, named (**Print Name**) _____, **Date of Birth** _____ to Family Medical Center for medical care.

CONSENT TO TREATMENT: I consent to the providing of examination by a medical provider and medical and/or surgical care by my physician, consulting physicians, and other health care provider including, but not limited to diagnostic and therapeutic tests and procedures and treatment as may be ordered by my physician, and/or his/her designees including consulting physicians to me (or my minor child or the patient named above). This consent includes but is not limited to the performance of invasive procedures, diagnostic procedures, administration of medications and any other procedures.

STATEMENT OF NON-DISCRIMINATION: Pinckneyville Community Hospital and Family Medical Center do not discriminate against any person on the basis of race, color, sex, national origin, disability (physical or mental), religion, age, sexual orientation, gender identity, sex stereotyping, pregnancy or status as a parent, in admission, treatment, or participation in its programs, services and activities, or in employment.

NOTICE TO PARENTS OR GUARDIANS: The parent or guardian must accompany a child under the age of 18 years, unless the parent or guardian has made prior written arrangements for care in their absence and the provider consents to this arrangement. Payment must be made regardless of who accompanies the child.

NOTICE TO DIVORCED PARENTS: The parent who brings the child to Family Medical Center is responsible for payment.

INSURANCE COVERAGE & FINANCIAL RESPONSIBILITY: I authorize my insurance company or organization to pay benefits directly to Family Medical Center, this being my assignment of benefits to said corporation. If notice or payment from my insurance company or my employer's worker's compensation insurance carrier has not been received within 60 days from the time of service, I understand that I will receive a billing statement informing me of the outstanding balance and possible problems or delays related to payment by my insurance provider. I understand that all patient portion amounts, including non-covered services, are due upon request and are payable to Family Medical Center. I further agree to pay any additional charges, not to exceed 25% of the balance due, in the event that I would fail to pay my bill, in addition to potential interest on outstanding balances of up to 12% per annum, and hereby give authorization to Family Medical Center to verify employment and credit history report on myself or responsible guarantor as part of those reasonable collection efforts. I do hereby authorize the CFO of Pinckneyville Community Hospital to endorse for me any checks made payable to me for benefits or claims collected on this assignment and to apply any credit balance to any other account I may owe Family Medical Center. For us to service your account or to collect any amounts you may owe, you agree to the Hospital, including its collection agency and legal counsel, may contact you or your spouse by telephone at any telephone number associated with your account, including wireless (cellular) telephone numbers which could result in charges to you, as well as telephone numbers of guarantors, insurance subscribers and emergency contacts listed on your account. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

PHONE NUMBER USAGE CONSENT: For us to service your account or to collect any amounts you may owe, you agree that Family Medical Center, including its collection agency and legal counsel, may contact you or your spouse by telephone, and may leave voicemail messages, at any telephone number associated with your account, including wireless (cellular) telephone numbers which could result in charges to you, as well as

telephone numbers of guarantors, insurance subscribers and emergency contacts listed on your account. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing device, as applicable.

TEXTING AND EMAIL NOTIFICATIONS: In order to provide you with the best possible care, we occasionally send convenient text messages and emails to our patients about appointment reminders, prescription order placements, wellness checkup reminders, pre-registration discussion, pre-operative instructions, lab result notifications, and post-discharge follow up, including collection or billing matters. Your wellness is important to us and we may also send you notifications about health care services that we offer including new service announcements, community education events and special events. Our goal is to provide you with relevant and useful information for improving your health. If you have provided your email and cell phone information upon registration, you hereby acknowledge consent to be contacted via email and text.

PRIVACY NOTICE: Our Notice of privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this form. By signing this form, you acknowledge that we have notified you of our notice of privacy practices posted in our facility and have provided a copy upon request.

PHOTOGRAPHS: The undersigned hereby authorizes Family Medical Center to photograph patient for identification for clinical purposes. Photographs for identification and clinical purposes are incorporated as part of the patient's medical record.

STUDENTS: Family Medical Center cooperates with colleges/universities to provide clinical experience to students. As a result, students may be observing and participating in patient care.

PATIENT PORTAL: I understand that I have the option to provide Family Medical Center with an email address permitting an email invitation to the Patient Portal upon discharge. I also understand that by providing an email address, I am consenting and understand that once information has been processed through secure electronic portals by me, I am responsible for the Confidentiality and Security of said information.

Relationship of Physicians & Advanced Practice Professionals ("Providers") to Pinckneyville Community Hospital: The following Providers are employed by Pinckneyville Community Hospital:

- Family Medical Center providers including Family Practice, Internal Medicine and Advanced Practice Professionals
- Dr. John Gregg Fozard, who works in the Family Medical Center and Hospital Inpatient setting
- Dr. Christopher Reyes, who works in the Family Medical Center and Hospital Inpatient setting
- Dr. Andrew Forbes, who works in the Family Medical Center and Hospital Inpatient setting
- Dr. David Cox, General Surgeon
- Dr. Sabrina Haque, who works in the Family Medical Center, Hospital Inpatient setting, and Emergency Department
- Miles Priebe, FNP-BC, Nurse Practitioner Hospitalist
- Leah Hopp, NP-C, Nurse Practitioner Hospitalist

All other Providers on staff at this Hospital and the Family Medical Center including, but not limited to attending physicians, emergency department physicians, pathologists, radiologists, anesthesia providers, consulting physicians, and specialty clinic providers, are independent contractors and are NOT employees or agents of the Hospital. If the Hospital bills for the professional services provided by independent contractors, it is done so per contractual agreement and to provide a consolidated billing statement for the convenience of the patient.

INITIALS: _____ I acknowledge that the employment or agency status of physicians and other providers who treat me is not relevant to my selection of Pinckneyville Community Hospital for my care. I acknowledge that any questions about the Independent Contractor Disclosure form and the important information contained in it have been answered to my satisfaction.

Notification of Payer Participation/Non-Participation and Non-covered Services: Prior to receiving any non-emergency services, you should contact your insurance plan to verify that the provider and/or physician is listed as a participating provider and if the services received are covered under your benefit plan. Even if the Hospital or practitioners providing services here are contracted to participate with an insurance plan network, that doesn't always guarantee that in-network status applies to your particular insurance plan. Your insurance plan may have a particular narrow network arrangement or require particular services to be obtained from a limited set of providers they approve. The Hospital is not going to know all the specifics of your particular plan. Therefore, if you receive services here, you are strongly encouraged to call the toll free telephone number on your insurance identification card to verify in-network and coverage status of services you are receiving. Be aware that when you elect to utilize the services of a non-participating provider for anything other than emergency services or services approved by the insurer in advance, the basis of your benefit payment will be determined according to your insurance policy's "out-of-network" fee schedules which will result in greater financial responsibility to you. Furthermore, if your plan does not cover specific services, or requires that you obtain certain services through only specific approved providers, you will be responsible for payment for any services deemed to be non-covered or out-of-network by your benefit plan. By signing this consent, you assume responsibility for verification of in-network status and are responsible for any services that your insurance plan processes as out-of-network or non-covered.

I CERTIFY:

1. That I have read or have had this consent read to me.
2. That I was given an opportunity to ask questions.
3. That all questions were answered to my satisfaction; and
4. That I understand this consent and accept its terms and conditions.
5. I understand this consent is valid and active for 1 year from date signed unless I otherwise notify Family Medical Center.

SIGNED_____DATE_____
(MUST BE SIGNED BY GUARDIAN IF UNDER AGE 18)

_____
RELATIONSHIP TO MINOR

Nondiscrimination Notice

Pinckneyville Community Hospital and Family Medical Center complies with applicable Federal civil rights laws and do not discriminate against any person on the basis of race, color, sex, national origin, disability (physical or mental), religion, age, sexual orientation, gender identity, sex stereotyping, pregnancy or status as a parent, in admission, treatment, or participation in its programs, services and activities, or in employment.

Pinckneyville Community Hospital:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats) or vision assistance aides (reading glasses or magnifying glasses/sheets)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services contact any employee, or Pinckneyville Community Hospital Administration, at phone number 618-357-5904.

If you believe that Pinckneyville Community Hospital has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Quality/Risk Manager, P.O. Box 437, Pinckneyville, IL 62274, Phone: 618-357-5976, Fax: 618-357-8888, or Email at riskmgr@pvillehosp.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Quality/Risk Manager is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Limited English Proficiency Taglines

As required to meet compliance with Section 1557 of the Affordable Care Act (ACA)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-618-357-2187 (TTY: 7-1-1).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-618-357-2187 (TTY: 7-1-1).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-618-357-2187 (TTY: 7-1-1).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-618-357-2187 (TTY：7-1-1)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-618-357-2187 (TTY: 7-1-1)번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-618-357-2187 (TTY: 7-1-1).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-618-357-2187 (رقم هاتف الصم والبكم: 7-1- 1).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-618-357-2187 (телетайп: 7-1-1).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-618-357-2187 (TTY: 7-1-1).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-618-357-2187(TTY: 7-1-1).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-618-357-2187 (TTY: 7-1-1).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-618-357-2187 (TTY: 7-1-1).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-618-357-2187 (TTY: 7-1-1) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-618-357-2187 (ATS : 7-1-1).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-618-357-2187 (TTY: 7-1-1).
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-618-357-2187 (TTY: 7-1-1).