General Consent for Treatment

I consent to any healthcare care, including, but not limited to, diagnostic procedures, laboratory testing and medical treatment as my physician(s) and/or other healthcare provider(s) deem necessary. If healthcare treatment is complex or the standard of care requires more involved, non-routine decision-making, my practitioner will discuss these with me and additional informed consent may be obtained. I understand that there are no warranties or guarantees regarding the services and care provided. Some care may be provided using telehealth technology and I consent to participate in telehealth consultations. I consent to the taking of photographs or video recordings that document conditions, treatments or procedures and understand that such images will be used for medical, scientific or teaching purposes only. I understand that the providers participating in my care, including my physician, may be either employees of Christie or independent contractors who are not employees or agents of Christie. I understand that the providers participating in my care have been granted the privilege of using Christie facilities for the care and treatment of their patients or are licensed practitioners participating in the care of patients as part of a post-graduate medical education program. I understand that as a teaching institution, medical residents and clinical students may participate in my care unless I request otherwise. Christie will attempt to honor the request to exclude a resident or clinical student where feasible and if such exclusion will not be detrimental to my healthcare.

Patient or Legal Guardian Signature: _____ Date: _____

Authorization to File/Release Information

Assignment of Benefits: I hereby assign all of my rights, interests and claims for all insurance reimbursement and all benefits payable under Medicare, Medicaid and any and all other insurance policies and health benefit plans to Christie Clinic for the services, treatments and/or medications rendered or provided by Christie Clinic ("Assignment"). I request payment of medical benefits and insurance reimbursement to Christie Clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

Authorization to Release of Information: I hereby authorize Christie Clinic to release any and all medical information to my insurance company, employee insurance group, health plan, Medicare/Medicaid program, its insurance carriers or intermediaries or the Social Security Administration ("Authorization"). Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to Christie Clinic any and all plan documents, summary benefit descriptions, insurance policies, and/or settlement information upon written request from Christie Clinic in order to claim such medical benefits.

The Assignment and Authorization are effective, valid and enforceable against any and all of my current and future insurance companies, employee insurance groups, health plans, Medicare/Medicaid programs, its insurance carriers or intermediaries, unless I revoke this Assignment and Authorization by notifying Christie Clinic in writing of such revocation. Any such written revocation is effective from the date of receipt by Christie Clinic. A copy of this Assignment and Authorization is to be considered as valid and effective the same as the original. BY SIGNING BELOW, I FULLY UNDERSTAND AND AGREE TO THIS ASSIGNMENT AND AUTHORIZATION.

Patient or Legal Guardian Signature: _____ Date: _____

Acknowledgement of Privacy Notice and Agreement to Patient Bill of Rights

I acknowledge that I received a copy of "Your Privacy Notice of Healthcare Information" from Christie Clinic. In addition, I acknowledge that I have received the "Patient Bill of Rights and Responsibilities" from Christie Clinic. By signing below, I agree to abide by the conditions and responsibilities as set forth in the Patient Bill of Rights and Responsibilities. I have had the opportunity to ask questions about the Privacy Notice and Patient Bill of Rights and Responsibilities and any questions that I have asked have been answered to my satisfaction.

Patient or Legal Guardian Signature: _____ Date: _____

Medication History Release Consent

I hereby give my consent to Christie Clinic to retrieve and use my medication history from an approved electronic prescriptions network. This is an electronic way for Christie Clinic to access patient prescription benefit information and patient medication history, and route prescriptions to a patient's pharmacy of choice. I understand that this medication history may not be completely accurate as some pharmacies do not make drug history available and might not include drugs that I purchased without using my health insurance.

By signing this consent form, I give Christie Clinic permission to collect, and give my pharmacy and my health plan permission to disclose, information about my prescriptions that have been filled at any pharmacy or that are covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions. This information will

become part of my medical record. This consent is valid and effective unless I revoke this consent by notifying Christie Clinic in writing of such revocation. Any such written revocation is effective from the date of receipt by Christie Clinic. A copy of this consent is to be considered as valid and effective the same as the original.

Patient or Legal Guardian Signature: _____ Date: _____

Consent to Calls and Text Messages

I hereby give Christie Clinic my express consent to call and/or text message my cell phone or home phone using automated technology and/or a pre-recorded voice message for any purpose, including without limitation, appointment reminders and collection on account balances. This consent applies to Christie Clinic's corporate affiliates and agents, including any third parties with which it may contract to deliver general messaging or electronic messaging services that use automated dialing technology and pre-recorded messages, phone calls or texts even if I am charged for the call or text under my phone plan. I hereby hold harmless Christie Clinic and any of the aforementioned entities or contractors, including Carle Foundation Hospital and it corporate affiliates, which I understand hosts Christie Clinic's shared electronic medical record system, from any loss, damage, or legal liability that I may claim to suffer as a result of receiving such text or telephone communications. I understand that I am not required to agree to such calls and/or text messages to my cell phone as a condition of receiving goods or services at Christie

(Continued on reverse side)

Clinic. I further understand that text messages may not be a secure method of communication and accept the risk of transmitting my health information via text messages. This consent is valid and effective unless I revoke this consent by notifying Christie Clinic in writing of such revocation. Any such revocation is effective from the date of receipt by Christie Clinic. A copy of this consent is to be considered as valid and effective the same as the original.

Patient or Legal Guardian Signature: _____ Date: _____

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires clinics to now obtain the following information. Christie Clinic providers will not use this information in their medical decision making.

Are you Hispanic, Latino/a, or Spanish origin?

a. ___Hispanic or Latino
b. ___Not Hispanic or Latino
c. ___ Prefers not to Report

What is your primary Language?

a. ___English
b. ___Other Language (specify) _____
c. ___Indian (includes Hindi and Tamil)
d. ___Spanish
e. ___Russian
f. ___ Prefers not to Report

What is your race?

a. ___American Indian
b. ___Asian
c. ___Native Hawaiian or Other Pacific Islander
d. ___Black or African American
e. ___White
f. ___Hispanic
g. ___Other Race
h. ___Other Pacific Islander
i. ___ Prefers not to Report

For office use only: Account Number _____