GENERAL CONSENT

This document applies to the following individuals who and entities that provide care to you: (1) clinical affiliates of Northwestern Memorial HealthCare ("NM Clinical Affiliates") including Northwestern Memorial Hospital ("NMH"), Northwestern Lake Forest Hospital ("NLFH"), and Northwestern Medical Group ("NMG"); and (2) "Independent Physicians" on staff at NMH or NLFH (but not affiliated with NMG).

I. GENERAL CONSENTS AND ACKNOWLEDGMENTS

A. CONSENT FOR DIAGNOSIS, CARE AND TREATMENT. I consent to diagnosis, care and treatment that I have agreed to receive and that is considered necessary or advisable by my physicians(s), including my attending physician and other healthcare professionals who may be involved in my care, and NM Clinical Affiliates, their employees and agents. I acknowledge that no guarantees have been made to me about the result of my examination or treatment at or by any NM Clinical Affiliate or Independent Physician. If I am pregnant, I agree that all the provisions in this General Consent also apply to my newborn child/children for their care and treatment while at NMH or NLFH after birth.

B. ACKNOWLEDGMENT OF EDUCATIONAL AND RESEARCH MISSIONS. NM Clinical Affiliates share a common mission of excellence in patient care, research and education with Northwestern University's Feinberg School of Medicine ("FSM"). I understand that my care will be provided in a teaching environment and that physicians, nurses, and other health care professionals in training may be involved in my care and treatment. I also understand that my health information may be used within the NM Clinical Affiliates and released outside the NM Clinical Affiliates for research purposes in accordance with law and the NM Notice of Privacy Practices. My physician(s) may discuss with me various research opportunities that may be of interest to me, but I do not have to agree to participate.

C. PHYSICIANS ARE NOT EMPLOYEES OF NMH or NLFH. I understand that **none of the physicians providing services to me at NMH or NLFH are employed by NMH or NLFH, and that neither NMH nor NLFH control or direct a physician's care of his or her patients.** This includes, but is not limited to, my treating and consulting physicians, Emergency Department physicians, radiologists, anesthesiologists, other specialists, and any allied health care providers whom they employ. The physicians and allied health care providers are independent medical practitioners who are permitted to use NMH and/or NLFH facilities for the care and treatment of their patients. My decision to seek care at either NMH or NLFH is not based upon any understanding, representation or advertisement that the physicians who are treating me are employees, agents or apparent agents of the NMH and/or NLFH. I also understand that I have the opportunity to request that my own physician participate during my care at either NMH or NLFH.

D. PERSONAL PROPERTY. I understand that the NM Clinical Affiliates will not be responsible for the loss, destruction or theft of any personal property that I bring with me to NM Clinical Affiliates. I assume full responsibility for all my personal property, including but not limited to my clothing, money, jewelry, glasses, dentures, hearing aids or other personal items, even if I use storage options available at the NM Clinical Affiliates. I release the NM Clinical Affiliates from responsibility and liability for such personal items and valuables.

II. HEALTH INFORMATION

I understand that the NM Clinical Affiliates record medical and other information related to my diagnosis, care and treatment (referred to as "my health information") in electronic, video, photographic, audio and other forms. I consent to production and internal use by the NM Clinical Affiliates of any videotape, photographs, audio records and other images containing my health information for education and for healthcare operations as defined in the NM Notice of Privacy Practices.

A. TREATMENT AND CONTINUITY OF CARE. As applicable, and when my consent is required by law, I consent to NM Clinical Affiliates' contacting or sharing my health information with other healthcare providers, such as Independent Physicians, physicians not on staff at NMH or NLFH, other hospitals, nursing homes, home health agencies, and pharmacies, to obtain information about my prior and current health conditions for treatment at an NM Clinical Affiliate or as necessary for treatment, continuity of care and discharge planning purposes.

B. MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/ALCOHOL AND DRUG ABUSE/HIV/AIDS/GENETIC TESTING & COUNSELING. **As applicable,** and when my consent is required by law, I consent to the following uses within and releases outside NM Clinical Affiliates relating to records of my treatment for mental health and developmental disabilities, alcohol and drug abuse, HIV, AIDS, and genetic testing and counseling ("sensitive health information"):

1. Sharing my sensitive health information by and between NM Clinical Affiliates and Independent Physicians and their employees for purposes of treatment, payment, and health care operations, as defined in the NM Notice of Privacy Practices.
2. Contacting and sharing my sensitive health care information with other healthcare providers as described in Section A above for the purposes described in Section A above, including releases made as part of the CareEverywhere© Program, as described further in the NM Notice of Privacy Practices.
3. Using my sensitive health information internally, or releasing my sensitive health information to FSM, to support healthcare operations as defined in the NM Notice of Privacy Practices.
4. Releasing my sensitive health information to FSM for research purposes as described in the NM Notice of Privacy Practices. More information about research at FSM is available at 312-503-9338.

C. OBSTETRICAL PATIENTS ONLY. I consent to the use of my health information by the physicians and NM Clinical Affiliate employees for the care and treatment of my newborn child/children. **As applicable,** and when my consent is required by law, I also consent to the sharing of my sensitive health information (defined above) between and among the physicians and NM Clinical Affiliate employees caring for my newborn child/children. I understand that the above health information and sensitive health information will be included in my new child/children's medical record for purposes of treatment and healthcare operations as described in the NM Notice of Privacy Practices.

D. RELEASE OF INFORMATION FOR BILLING AND BENEFITS. **As applicable,** and when my consent is required by law, I consent to the release by the NM Clinical Affiliates and Independent Physicians of my health and other information, including my sensitive health information, to any private health insurance plan, Medicare, Medicaid, other governmental insurance program, other third-party payor or benefits provider that I identify, or their agents, as needed for NM Clinical Affiliates and Independent Physicians to obtain payment for the treatment and services provided to me. If I do not consent or later revoke this consent, I understand that I will be responsible to pay for the treatment and services received.

I agree that my consents as set forth in Section II(B)--(D) shall apply to all sensitive health information in the Clinical Affiliate's possession, including information concerning care received prior to or after the date of this document. I may revoke (take back) my consents set forth in Section II by providing written notice to the address noted in the NM Notice of Privacy Practices. My written revocation shall not apply to uses and releases already made by the NM Clinical Affiliates based upon the above consent. If not revoked or superseded by my signing another consent, the above consent will expire 5 years from the date below. I understand that I have the right to inspect and copy any of my sensitive health information to be released and that my sensitive health information may not be re-disclosed by any recipient without my further consent or except as required or permitted by law.

III. FINANCIAL CONSENTS AND ACKNOWLEDGMENTS

A. RESPONSIBILITY FOR PAYMENT. I agree that I am financially responsible to and agree to pay NM Clinical Affiliates and my Independent Physician(s) for all services, facilities and supplies provided to me. NM Clinical Affiliate bills will be based upon the current rates contained in each NM Clinical Affiliate's respective Charge Master, which is a list of charges for services, supplies and facilities received from the NM Clinical Affiliate. I understand that more information about my bill can be found in the NM brochure regarding patient billing and financial assistance.

If I choose to have my health insurance (including private insurance, Medicare, Medicaid, other governmental or other insurance programs) cover my treatment, I authorize the NM Clinical Affiliate to bill any such insurer for all medical services and products provided. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment or charges not covered by my health insurance. The NM Clinical Affiliate will bill me for the amount that is my responsibility. I will not be responsible for any charges over the payor rate my insurer may have established by contract with the NM Clinical Affiliate for covered services. I understand that my insurer may deny payment for services that the insurer decides are not "medically necessary" or that are "experimental." While NM Clinical Affiliates will take reasonable steps to appeal these denials, I understand that I am responsible for paying for services denied by my insurer, including those deemed medically unnecessary or experimental.

B. ASSIGNMENT OF BENEFITS. If I choose to have my health insurance pay for my treatment, I give up my rights to receive payment from my health insurer and assign the rights to receive payment to NM Clinical Affiliates and Independent Physicians

involved in my care. I agree to cooperate and provide information as needed by the NM Clinical Affiliates and/or Independent Physicians to establish my eligibility for my insurance benefits. If I claim benefits under Title XVIII of the Social Security Act (Medicare), I hereby certify that the information I provide in applying for payment of such benefits is correct.

C. FAIR PATIENT BILLING ACT NOTICE.
I understand the following:

- I may receive separate bills from each NM Clinical Affiliate and Independent Physician for the services provided to me.
- NM Clinical Affiliates and Independent Physicians may not be participating providers in my insurance plan or network. If not, I may have greater financial responsibility for their services.
- Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. NM Clinical Affiliates do not guarantee that a service or product will be covered by my health insurance.

D. FINANCIAL ASSISTANCE. If I am uninsured or have difficulty paying my NM Clinical Affiliate bill, I understand that NM Clinical Affiliates have many financial assistance options, including free care, discounted care or interest-free payment plans. Financial counselors can be reached toll free at 800-423-0523.

IV. RECEIPT OF WRITTEN MATERIALS

When applicable, I acknowledge receipt of:

□ An Important Message from Medicare □ An Important Message from Tricare □ Patient Rights and Responsibilities	□ Notice of Privacy Practices □ Medicare Beneficiary Notice of Co-Insurance □ Patient Billing and Financial Assistance □ Observation Care Information

I HAVE READ and fully agree to each of the statements in this form and sign below as my free and voluntary act. NM Clinical Affiliates will not be bound by any changes I make to this document. Except for services that I receive on an emergency basis, I understand that if I refuse to sign this document as presented, the NM Clinical Affiliates may not be able to provide services to me.

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Signature of Patient or Legally Authorized Representative — Date of Signature

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Relationship of Legally Authorized Representative to Patient

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Witness Signature — Date of Signature