This consent applies to all St. Luke's Hospital & Clinic locations where I receive care. It applies to me and, if I'm pregnant, to any child I give birth to at St. Luke's.

Consent for treatment: I understand that I have a condition that requires diagnosis & treatment. I will have a chance to discuss with my provider the treatment that my care team believes is needed. St. Luke's cannot promise specific results. To provide this care, St. Luke's may collect information about my health, including genetic information such as family health history.

If I am seeking care at a hospital & have an emergency medical condition (as defined in the Emergency Medical Treatment & Active Labor Act), St. Luke's will provide care to stabilize me, even if I have no insurance or cannot pay.

When a health care worker is exposed to my blood or other potentially infectious materials through any eye, mouth, or other mucous membrane, non-intact skin or parenteral contact, I consent to a test of my blood to screen for the presence of hepatitis B, hepatitis C, human immunodeficiency virus (HIV), or any antibody to HIV virus, the cause of acquired immunodeficiency syndrome (AIDS). I also consent to the release of reasonably necessary portions of my medical record to assist St. Luke's in assessing potential risk related to such exposure. I understand that I may have the right to consent to release my test results to myself &/or my primary physician.

Authorization to Release/Access Information: St. Luke's & approved agents of St. Luke's may release or access my health records, including workers compensation, pharmacy medication records, & transfer records, to providers, community health agencies or other groups outside of St. Luke's for use in treatment, including coordinating my care.[1] St. Luke's may share my health records with quality or other organizations for health care operations as described in St. Luke's Privacy Notice. St. Luke's will store my records for as long as its policy requires. If I am in the hospital, St. Luke's may tell others that I am a patient here. It will not give out my private information. This allows me to have visitors, phone calls, & mail. If I do not want others to know I am here, I will tell a staff member when I register.

I may revoke this consent at any future date upon written notification to St. Luke's. However, I understand St. Luke's may release information in good faith from the date I sign the consent until the date I may choose to revoke it.

Health Care Students in Training: Medical, nursing & other students may be present or involved during my care. St. Luke's must approve their presence or involvement. Any help they give will depend on their training.

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

Insurance, Assignment of Benefits & Guarantee of Account: St. Luke's may bill my insurance. I ask that my insurance payments be made to St. Luke's & to providers of my care. St. Luke's may share my health & account records with payers, & their approved agents, as needed for billing, payment, claims, & quality reviews. I will pay for all services not covered or paid by a third party, such as insurance, including emergency services.

Charges/Estimates: My total charges will not be known until my care is complete. St. Luke's will charge its current rates. My balance due may differ from that of other patients depending on my insurance (or lack of it). For facility/hospital charges, I may request an estimate by calling (218) 249-5340. For clinic charges, I will contact the clinic where I will receive care.

For Those With No (or not enough) Insurance: If I need help paying for my care, I will ask about my options when I register. St. Luke's will use a screening program to see if I can get help paying my bill.

Release of Information by Insurers: My health care insurer may share with St. Luke's & its approved agents my health & account records for the care I have received from St. Luke's & non-St. Luke's care providers. This information may be used as needed to provide the best possible care. It may be used to manage or coordinate my care & to improve the quality of that care. If I do not agree to this, I will initial below.

_____My insurers may not release my health & account records from St. Luke's & non-St. Luke's providers as described above.

Valuables: I am responsible for my own valuables. If I am staying in the hospital, I will be requested to either send home any valuables with family/friends or secure them in the hospital safe. This includes money, jewelry & electronic devices. I release St. Luke's from any liability for the loss or damage of items not secured in the hospital safe.

Photos or Audio/Video Recordings: St. Luke's may take photos or audio/video recordings as needed to identify, treat, or supervise me. If I do not want photos or audio/video recordings taken, I will let staff know. If photos or audio/video recordings are used for teaching, my name or other information that would identify me will not be shown.

Communication: I understand St. Luke's may need to contact me in regard to my services & accounts. I give permission for St. Luke's & its approved agents to contact me by email or phone (including my cell phone). This may include the use of auto-dialers or pre-recorded messages.

I understand the content & accept the terms on this consent form. If I have concerns with parts of this consent, I will discuss them with the employee who is helping me with this form.

Notice of Privacy Practices: I have received St. Luke's Notice of Privacy Practices. This Notice explains my rights to my medical information, and it describes how that information may be used and disclosed.

1. Health records include information about mental & physical health, health care, payments for health care & demographic information.

Printed Name of Patient	Date of Birth
Signature of Patient or Authorized Representative	Date / Time
Printed Name of Authorized Representative	Relationship to Patient

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

CONSENT FOR SERVICE

St. Luke's

C.CONSENT

Patient Label