

## **GENERAL CONSENT**

### **I. General Consents and Acknowledgements**

#### **A. Consent for Diagnosis, Treatment and Care**

I give permission for NUCASLL to provide medical services such as diagnosis, treatment, and clinical procedures that may be deemed necessary on my behalf. I acknowledge that no guarantees have been made to me about the results of my examination or treatment by any NUCASLL clinician.

#### **B. Acknowledgment of Educational and Research Missions**

NUCASLL is dedicated to promoting quality services to the community. This mission is accomplished by providing clinical care, training future professionals, and participating in clinical and translational research. I understand that my care will be provided in a teaching environment and that professionals in training will be involved in my care and treatment.

#### **C. Recording**

I am aware that audio and video recordings are used routinely during diagnostic (testing and interviewing) and treatment sessions and that there may be observers present during these sessions at Northwestern University. I, on behalf of myself and/or my minor child authorize audio and video recordings for clinical diagnostic, treatment and educational purposes within and external to Northwestern University including local and national conferences by Northwestern University faculty and I will make no monetary or other claims against the University for their use. I understand that this permission extends to any and all sessions that I (or my minor child, if applicable) have at the Center for Audiology, Speech, language and Learning.

#### **D. Communications**

By signing this consent form, you give NUCASLL (Northwestern University Center for Audiology, Speech, Language and Learning) permission to communicate with you via text messages, unencrypted emails, or phone calls for appointment reminders, updates and other necessary communications not containing your health information. By consenting, you acknowledge that unencrypted methods of communication are less secure, and you understand that you can opt out of these methods of communication at any time by calling NUCASLL at 847-491-3165. Communications originating from NUCASLL that contain your health information will continue to be sent exclusively through encrypted email.

### **II. Health Information**

I understand that NUCASLL records medical and other information related to my diagnosis, care, and treatment in electronic, video, audio and other forms. I certify that any information regarding my history or medical condition communicated to NUCASLL is true and complete to the best of my knowledge. I understand that my medical information is confidential and will only be released to others with my consent. I give permission for NUCASLL to exchange medical information with my insurance company and/or their designated agents, the insurance policy holder, and/or other providers of healthcare services for purposes of insurance certification for tests or procedures recommended by NUCASLL providers. I also give permission to NUCASLL to provide medical information necessary to provide continuity of care recommended by NUCASLL staff to non-NUCASLL providers of healthcare or related diagnostic or therapeutic services.

### III. Financial Responsibility

I agree that I am financially responsible to and agree to pay NUCASLL for all services provided to me. NUCASLL bills current rates based on NUCASLL Chargemaster, which is a list of charges for services and supplies and discounted rates that may apply to those services or supplies.

If I choose to have my health insurance cover my treatment, I authorize NUCASLL to bill any such insurer for all medical services and products provided. My insurance company may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, or charge not covered by my health insurance. NUCASLL will bill me for the amount that is my responsibility. I understand my insurer may deny payment for services that the insurer decides are not “medically necessary” or that are “experimental”. While NUCASLL 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.

If I choose to have my health insurance pay for my treatment, I give up my rights to receive payment from my health insurance and assign the rights to receive payment to NUCASLL. I agree to cooperate and provide information as needed by NUCASLL to establish my eligibility for my insurance benefits.

### IV. Receipt of Written Materials

I acknowledge receipt of NUCASLL’s Notice of Privacy Practices.

### V. Research

NUCASLL is housed within Northwestern University’s Roxelyn and Richard Pepper Department of Communication Sciences and Disorders (CSD), which houses a strong research arm and helps support our mission of delivery of high-quality clinical care. As a patient at NUCASLL, you are granted the opportunity to participate in a variety of research studies. Unless I check the “I do not agree” circle below.

I give permission for NUCASLL to share my contact information with NU CSD researchers so that I may be contacted about participating in research projects.  I do not agree.

I give permission for NU researchers to access my past and future clinical information housed in NUCASLL medical record systems for research purposes. The information will always be used in an anonymous manner.  I do not agree.

### VI. Marketing and Education

Unless I check the “I do not agree” circle below, I agree that to receive newsletters, fundraising information, and news about upcoming events, specials and articles pertaining to services or products in the clinic.  I do not agree.

### VII. Signature

My written or electronic signature indicates my agreement with and acknowledge of the above.

\_\_\_\_\_  
**Name of Patient (Printed)**

\_\_\_\_\_  
**Signature of Patient, Parent if patient is under 18, or Legally Authorized Representative**

\_\_\_\_\_  
**Date of Signature**

\_\_\_\_\_  
**Relationship of Legally Authorized Representative to Patient**