PATIENT ACKNOWLEDGMENT AND CONSENT FORM

ON BEHALF OF MYSELF OR OTHER PATIENT NAMED BELOW, I ACKNOWLEDGE AND CONSENT TO THE STATEMENTS MADE IN THIS FORM. CHANGES OR ALTERATIONS TO THIS FORM ARE NOT BINDING ON OAK STREET HEALTH AND/OR ITS AFFILIATED FACILITIES (EACH AND ALL OF THEM REFERRED TO AS "OAK STREET" IN THIS FORM).

General Consent to Treat: I am requesting that health care services be provided to me (or the patient named below) at Oak Street. I voluntarily consent to all medical treatment and health care-related services that Oak Street considers to be necessary for me (or the patient named below), including integrated behavioral health services.

Consent to Tele-Health Services: I understand that Oak Street may provide certain services by remote telehealth technology, including, but not limited to, tele-behavioral health. Such tele-behavioral health services involve a health provider who is at a site remote from my location at the time of the service, and, as such, often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription.

Financial Responsibility and Assignment: Subject to applicable law and the Oak Street Financial Assistance Policy, and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay Oak Street for the patient balances due.

Assignment of Benefits/Third-Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign to Oak Street all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding Oak Street's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. I consent to any request for review or appeal by Oak Street to challenge a determination of benefits made by a third-party payer.

Use and Disclosure of Health Information: I have received Oak Street's Notice of Privacy Practices. The Notice of Privacy Practices explains how Oak Street may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let Oak Street use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices. I consent to participate in one or more health information exchanges (HIEs) and Oak Street may electronically share your health information with other HIE participants for treatment and payment purposes. I authorize Oak Street to utilize your health information to identify services through predictive analytics that may be of benefit to you.

Patient Consent for Chronic Care Management: I have received Oak Street's Consent for Chronic Care Management Services, and **consent / do not consent** to Oak Street providing such chronic care services as described in the CCM Consent form.

Consent to Receive Texts/Pre-recorded Calls: I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to Oak Street on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from Oak Street, or other third parties who may act on its behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from Oak Street or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

Consent to Photograph: I hereby consent and grant to Oak Street the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by Oak Street.

ACKNOWLEDGMENT/RECEIPT OF ALL FORMS ABOVE

BY SIGNING BELOW, I AM INDICATING THAT I HAVE REVIEWED AND ACKNOWLEDGE AND CONSENT TO THE TERMS DESCRIBED ABOVE.

Signature of Patient or Responsible Party	Date
Printed Name of Patient (or Responsible Party if not the Patient)	Responsible Party's Relationship to Patient

Location

Phone

Address

City State Zip