HEALTH™

MEDICAL GROUP

CONSENT FOR TREATMENT, ASSIGNMENT AND RELEASE OF INFORMATION FOR PAYMENT

PATIENT'S NAME:

DATE OF SERVICE: MR#_______________________

CONSENT FOR MEDICAL TREATMENT
I voluntarily authorize and consent to the administration and performance of any or all diagnostic tests, therapeutic treatments and procedures considered necessary or advisable by members of the medical staff, allied practitioners, personnel and independent contractors of Alexian Brothers Ambulatory Group d/b/a AMITA Health Medical Group (AHMG). I understand I have the right to revoke this consent, in writing, at any time, except to the extent that AMITA Health Medical Group has taken action in reliance of this consent. It is anticipated that I (the patient) will require a series of services, and this consent for treatment shall be ongoing until such time as I am no longer a patient of AMHG or otherwise revoke this consent.

INDPENDENT PHYSICIAN SEVICES
I understand that some physicians who may provide professional services to me (including but not limited to radiologists, pathologists and consulting physicians) are neither employees or agents of AHMG and are independent contractors who will be providing their specialized services. The services of these physicians will be billed separately.
I am aware and understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees can be or have been made as to the result of any diagnosis, treatment, test, procedure or examination conducted performed at AHMG.

INFORMED CONSENT
I understand that I have the right to discuss and ask questions of my treating provider about my condition and any recommended medical or diagnostic procedures, and the risks and benefits thereof, in order to make an informed decision regarding my healthcare.
DISCLAIMER AS TO VALUABLES
I hereby release AHMG and any of its medical staff, allied practitioners, personnel and independent contractors from any liability that may be incurred from the loss or damage of valuables and personal items I have kept in my possession while in this facility as a patient.

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Initials

RELEASE OF PATIENT INFORMATION
I hereby authorize AHMG and its medical staff, allied practitioners, personnel and independent contractors, to discuss with and release copies (electronic or print) of the pertinent information from medical records to my employer group, insurance company, or other third party payer and their agents, as well as any review organization or government agency for the purpose of a) determining eligibility, available benefits, and obtaining payment on my behalf for the health services provided, b) to another health care facility or physician for further medical care, and c)

for any other purpose authorized by law. I understand this released information concerning medical care, advice or treatment may include the following information: history and physical, diagnosis, laboratory results, diagnostic testing and specific information concerning alcohol abuse, mental health, drug abuse, human immunodeficiency virus (HIV), hepatitis, or other infectious diseases. This authorization is valid until such time as all available insurance benefits have been received. I understand that I have the right to revoke this authorization. However, in the event that my revocation prevents payment for the services received, then I will assume responsibility for payment.

PATIENT PRECERTIFICATION RESPONSIBILITY

I understand that I am responsible for the notification of my insurance company to obtain any necessary authorization before series are rendered, if required by my insurance company. I further understand that if I do not pre-certify my treatment, I may incur a reduction or loss of paid benefits to AHMG for which I will be responsible.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT GUARANTEE

In consideration of medical services tendered by AHMG's medical staff, allied practitioners, personnel and independent contractors, I hereby assign, transfer and set over to AHMG and its independent contractors all of my rights, title and interest to medical reimbursement, including, but not limited to, the rights to appeal and obtain administrative and judicial review of any denial of benefits for healthcare services rendered to me by AHMG's medical staff, allied practitioners, personnel and independent contractors.

FOR MEDICARE CHAMPUS/VA RECIPIENTS ONLY

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers any information needed for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf, directly to AHMG and my treating physician(s). I authorize the Social Security Administration to release my Medicare number Part A and /or part B Eligibility effective dates and birth date to AHMG. My initials below acknowledge my receipt of "An Important Message from Medicare or CAMPUS" from AHMG on the date noted and does not waive any of my rights to request a review or make me liable for payment.

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Initials

PRIVACY PRACTICES

I understand that I have the right to review AHMG's Notice of Privacy Practices prior to my signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur during the course of my treatment, payment of my bills or in the performance of health care operations of AHMG. This Notice of Privacy Practices also describes my rights and AHMG's duties with respect to my protected health information.

AMITA HEALTH™
MEDICAL GROUP

PATIENT NOTIFICATION

I voluntarily authorize and consent for AHMG to call my home or other alternate location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out Treatment, Payment and Operations (TPO), such as appointment reminders, insurance items and phone calls pertaining to my medical care. AHMG may e-mail me or mail to my home or other alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and any health promotions for disease management, preventative care and wellness programs pertaining to my medical care as long as they are identified “Personal and Confidential”.

I understand I am financially responsible for charges not covered by this authorization.

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Initials

I acknowledge that I have read this consent form (or a large print version) and have had the opportunity to ask any questions.

_______________________________	_______________________________
Patient or Legal Representative’s Signature	Guarantor and/or Insured Person’s Signature (if other than patient)
Witness Signature	Witness Signature

Please identify by name family members, a relative, or any other person who might directly be involved in your health care:

Authorized Individual Name	Relationship	Phone Number