# Covenant Clinic

Wheaton Franciscan Healthcare

## Physician Office Consent for Treatment & Financial Agreement

Name ______________________________________________ Date of Birth _________________

**A.** **Consent for Treatment:** I give consent to my physician, other attending physicians and their assistants and designees, to provide me with such medical, surgical, diagnostic, or other treatment services judged necessary and/or appropriate. This consent includes my consent for diagnostic procedures and all medical treatment rendered at my physician's office under his/her instruction; including x-ray, laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues, and/or parts may be removed from my body. I authorize my physician and his/her personnel to preserve or use such cells, tissues, or parts for teaching purposes and/or to dispose of any cells, tissues, or parts that are removed.

**B.** **General Acknowledgments:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results of my examinations or treatments. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at my physician's office. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place during regular business hours.

**C** **Assignment and Agreement to Pay:** I understand that I am responsible for payment of the services I receive and guarantee payment for these services. I hereby assign to the physicians, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of physicians and/or the professionals associated with an office practice. Therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payors, or others for billing purposes. In addition, I understand that I may receive separate bills from independent physicians involved in my care; including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks.

**D.** **Insurance Acknowledgment:** I acknowledge that it is my responsibility to understand the benefits of my insurance plan and its requirements when seeking treatment and/or care not provided by my primary care provider.

**E.** **Privacy Notice:** I acknowledge that I was provided with a copy of the Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

______________________________________________ ______________________

Signature of Patient/Authorized Representative Date

______________________________________________

Relationship of Authorized Representative

If unable to sign document, state reason: ______________________________________________