ENGLEWOOD HEALTH
PHYSICIAN NETWORK

CONSENT FOR TREATMENT, ASSIGNMENT OF INSURANCE BENEFITS, RELEASE OF INFORMATION AND FINANCIAL AGREEMENT

1. **CONSENT FOR TREATMENT**

   The undersigned consents to any x-rays, laboratory or other medical procedures or examination rendered to me under the general and specific instructions of my physician(s). I acknowledge that no guarantees have been made to me as to the result of treatment/ examination in Englewood Health Physician Network. I also consent to the testing of my blood for Human Immunodeficiency Viruses (HIV) and/or other blood borne pathogens, in the event that any individual at an Englewood Health Physician Network practice is accidentally exposed to my blood or body fluids, or my physician believes such testing is medically indicated. Results of such testing will be reported to me, noted on my medical record and reported to the State Department of Health as required by law.

2. **RELEASE OF INFORMATION**

   Englewood Health Physician Network is hereby authorized to release any/all of my medical records to the person(s) liable for my financial obligations resulting from services and to use data from my medical record for quality, epidemiology and education studies to which no identifying information will be made public. I authorize Englewood Health Physician Network to download my historical medication information from Sure Scripts.

3. **ASSIGNMENT OF INSURANCE BENEFITS**

   In the event the patient is entitled to physician benefits of any type arising out of any policy of insurance coverage from the patient or any other party liable for the patient, said benefits are hereby assigned to Englewood Health Physician Network and/or treating physician. In the event the patient's insurer denies medical benefits, coverage, or payment, consent is hereby authorized to allow Englewood Health Physician Network and/or treating physician to appeal such decisions on the patient's behalf.

4. **MEDICARE BENEFITS (IF APPLICABLE)**

   I certify that the information given by 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 or its intermediaries or carriers any information needed for this or a related Medicare claim. I assign the benefits payable for services to Englewood Health Physician Network or the physician furnishing the services and authorize Englewood Health Physician Network or the treating physician to submit a claim to Medicare for payment.

5. **MEDICAID**

   I certify that services covered by this claim have been received and I request that payment for these services be made on my behalf. I assign the benefits payable for practice services to Englewood Health Physician Network and/or treating physician. I authorize Englewood Health Physician Network or the physician to submit a claim to Medicaid for payment on my behalf. I authorize the release of my medical information necessary to process this claim in accordance with program policy.

6. **OTHER PHYSICIAN SERVICES (OUTSIDE OF OUR PRACTICE)**

   In the event the patient is entitled to benefits of any type arising out of any policy of insurance covering the patient, that said benefits are also hereby assigned to any other physicians (outside of our practice) providing services to you at our request. I understand that it is the responsibility of the patient to obtain information from his/her insurance company to determine if the above mentioned physicians are participating in the patient's insurance plan. Participation by Englewood Health Physician Network in any given insurance plan does not indicate participation by the other physicians outside of this Practice. I understand that I am responsible to the other physicians' practices for any charges not covered by my insurance plan.

7. **FINANCIAL AGREEMENT**

   I agree, whether signing as agent or patient, that in consideration of the services rendered to the patient, I am hereby individually obligated to make payment to Englewood Health Physician Network in accordance with the regular rates and terms of Englewood Health Physician Network. I understand that I am responsible to Englewood Health Physician Network for any amounts billed to and not covered by any insurance carrier(s), including any amounts denied by the insurance carrier for no pre-certification or referral. Should the account be referred for collection after a default, I agree to pay costs of collection, including reasonable attorney's fee. All delinquent accounts bear interest at legal rates.

The undersigned certifies that he/she has read and understands the foregoing, receiving a copy thereof and as a patient or the patient's agent, authorized to execute the above, accepts its terms.

_____ _____ _____

Patient Signature/Authorized Agent Date Print Name Patient Signature/Authorized Agent

I acknowledge that I have been provided with a copy of Englewood Health Physician Network Privacy Notice.

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Patient Signature/Authorized Agent Date