Consent to Treatment, Consent to Release of Health Care Information and Payment Agreement

Consent to Treatment

This Consent to Treatment, Consent to Release of Health Care Information and Payment Agreement ("Agreement") pertains to the treatment of the signatory below (the "Patient") at Adventist Health Partners (the "**Physician Office**"). The Patient and/or the individual signing this Agreement on the Patient's behalf hereby agree to comply with all clinical visit requirements of the Physician Office. For purposes of this Agreement, "I," "me", "my" and "myself" refer to the Patient, the Patient's legal representative and/or the Patient's principal obligor, as appropriate.

As part of the course of my care and/or diagnosis and treatment of my medical condition, I voluntarily consent to receive services and care from the Physician Office.

Consent to Participation in Health Information Exchange

Receipt of Adventist Midwest Health Notice of Patient Privacy Practices (Acknowledgement)
By signing this Agreement, I hereby expressly acknowledge my receipt of Adventist Midwest Health Notice of Patient Privacy Practices. The Adventist Midwest Health Notice of Patient Privacy Practices describes how information may be accessed, used and disclosed and how I can access my own medical information.

Health Information Exchange
Health information exchange allows health care providers to share health care information about patients electronically for several purposes, such as treatment, quality assurance and state law reporting requirements. I understand that if I go to the Physician Office for treatment, the Physicians and/or their staff may get a copy of my health care information electronically through various health information exchange connections with other health care providers.

I consent to the use and release of all my health care information, including but not limited to mental health, HIV/AIDS, genetic testing, rape/sexual assault, and child abuse/neglect information, for treatment, payment and health care operations, among the affiliated entities of Adventist Health System listed in the Physician Office's Notice of Patient Privacy Practices, as amended from time to time.

I understand I may request that my health care information not be shared through electronic health information exchange by checking the box below

___ Decline

Substance Abuse
I authorize the Physician Office and Adventist Health System to release all of my substance abuse health care information (which includes drug and alcohol abuse information) to the hospitals, physicians and care providers who are treating me and are affiliated with (owned or operated by) Adventist Health System for my treatment, payment of the health care services I receive and health care operations activities, like quality assurance and peer review. The list of Adventist Health System affiliated entities is available in hard copy form at the front desk of any site of service or on the websites of Adventist Health System.

I understand that this authorization for release of substance abuse health care information may be terminated at any time, unless Adventist Health System and its affiliated hospitals, physicians and care providers have already acted in reliance on it. If not previously revoked, I understand that this authorization is effective until I die. I further understand that I may decline to sign this authorization today by checking the box below.

___ Decline

Payment

UNLESS YOU ARE A MEMBER OF ONE OF THE PHYSICIAN OFFICE'S CONTRACTED INSURANCE PLANS, OR MEDICARE, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD.

PPO Plans

If the Physician Office is contracted with your plan, the majority of members covered under this type of plan are still required to make some type of payment for service that is rendered to them. This may be in the form of co-payment, deductible or co-insurance. If your plan has a co-payment, you will be expected to pay your co-payment prior to being seen by the doctor. Co-payments, deductibles and co-insurance are requirements of your insurance plan and the Physician Office is required under our contract with these plans to collect these amounts from you.

POS and HMO Plans

Most of the members covered under POS and HMO plans also owe co-payments, and members of POS plans may also owe deductibles and/or co-insurance. Co-payments will be collected prior to being seen by the doctor. You will be billed for co-insurance and deductible amounts. The Physician Office is required under our contract with these plans to collect these amounts from you.

Balances on Account

All previous balances are to be paid in full prior to additional services being rendered.

Re-Billing Charge

In the event that your insurance company has paid their portion and the balance remaining is your financial responsibility, the Physician Office expects that you will pay any co-insurance, deductibles, or any other balance in a timely manner. Should your payment fail to reach the Physician Office prior to the generation of a second billing statement to you, a re-billing charge of $10.00 will be added to your total balance due. This amount will be added to your balance each month until your account is paid in full. For your convenience, we accept Visa and MasterCard payments by phone.

Collections

Should it become necessary for the Physician Office to utilize the services of an outside collection agency in order to collect the amounts which are due and owed by you under the terms of your insurance coverage, you will be held liable for any and all collection agency fees and/or attorney fees which will be approximately 21% over and above the actual charges for services which were rendered to you. Further, information that is helpful or necessary for collection purposes will be forwarded to our professional collection agency.

Assignment of Benefits and Medical Records Release

I hereby authorize my insurance benefits to be paid directly to the Physician Office realizing I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

THE UNDERSIGNED MAY RECEIVE A COPY OF THIS AGREEMENT UPON REQUEST, AND CERTIFIES THAT HE OR SHE HAS READ THIS AGREEMENT AND HAS BEEN ABLE TO ASK QUESTIONS.

Printed Name of Patient	**Printed Name of Witness**
Patient's Signature & Date	**Witness' Signature & Date**
Printed Name of Legal Representative/Principal Obligor	**Legal Representative/Principal Obligor's Signature & Date**
Relationship to Patient (Self, Legal Representative, Principal Obligator, General Agent)	**Printed Name of Interpreter [if applicable]**