OUTPATIENT UNIVERSAL CONSENT

_____ I understand that by presenting myself for health care service, I authorize and consent to the performance of any and all tests, treatments, and procedures which may be ordered by my physicians. I consent for such treatments and procedures to be carried out by physicians and other healthcare providers. I am aware that among those who may be caring for me are medical, nursing, and other health care personnel who are in training.

_____ I acknowledge that I have been offered a copy of Central DuPage Physician Group's Notice of Privacy Practices. I further understand that the Notice of Privacy Practices describes how Central DuPage Physician Group may use or disclose my medical information in providing care to me and receiving payment for that care. Further, I understand that I may authorize other individuals to be involved in my care in the space provided below marked "Personal Representatives". Lastly, I understand that I may review the Notice of Privacy Practices at Central DuPage Physician Group's internet site at www.cdh.org.

Personal Representative(s): _____
(Please Print)
_____

ASSIGNMENT OF BENEFITS & PAYMENT AGREEMENT

The undersigned hereby assume(s) full responsibility for and agree(s) to pay all costs charges and expenses of every description incurred by the patient in the full amount billed to **Central DuPage Physician Group (CDPG).** I understand and agree that this understanding constitutes a direct primary and personal undertaking by me to CDPG, and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. An Assignment of Benefits of any insurance policy or medical reimbursement plan shall not be deemed a waiver of CDPG's right to require payment directly from the undersigned or the patient. CDPG expressly reserves its right to require such payment. No extension, indulgences or forbearances which may be granted to the patient, and no delays or lack of diligence of CDPG to enforce its rights against the Patient shall in any manner release the undersigned or affect the undersigned's liability hereunder. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all cost of collection, including, but not limited to reasonable attorney's fees.

I represent that I presently maintain insurance which will reimburse the charges for CDPG and the medical care being provided. In consideration of these physician and medical services, I hereby assign, transfer and set over to **Central DuPage Physician Group,** all of my rights, title and interest to medical reimbursement benefits under my insurance policy(s) as indicated below. If my insurance benefits are provided through an ERISA plan. I hereby assign, transfer, and set over all my rights, title and interest as a beneficiary of ERISA plan to **Central DuPage Physician Group,** with regard to my treatment and care

_____ I acknowledge that I have read and understand this form, that I have been given the opportunity to ask questions, and that I have no remaining questions at this time.

X_____ _____ _____
Signature of Patient or Representative | Date | Relationship to Patient

X_____ _____
Signature of Witness | Date

Place Patient Label Here