

CENTRAL DUPAGE PHYSICIAN GROUP

Patient Name: _____

Account # _____

(Please Print)

CONSENT FOR TREATMENT

I acknowledge and understand that, in presenting myself for treatment and continuing medical care at a Central DuPage Physician Group Practice (CDPG), a Central DuPage Hospital facility, that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of the CDPG Medical staff and personnel.

Minors must be accompanied by a parent/legal guardian for medical care except when the minor is seeking specific services for which they are not required to obtain parental consent, accompaniment or guidance, as clearly expressed by State law.

ASSIGNMENT OF BENEFITS

In consideration of these medical services, I hereby assign, transfer and set over to the Central DuPage Hospital and/or CDPG, all 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 (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all my rights, title and interest as beneficiary of the ERISA plan to CDPG, with regard to my treatment and care with this CDPG practice.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

I authorize CDPG to release medical information or copies from my medical record within a reasonable time frame to insurance companies, third party payers, or authorized agents; or claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employers insurance companies or their designees who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked in writing at any time.

PAYMENT AGREEMENT

I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient, to Central DuPage Hospital/CDPG. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. And assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of the Provider's right to require payment directly from the undersigned. The Provider expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person every obligation hereunder shall be joint and several.

All deductibles and co-pays are due at the time of service. We accept cash, checks, or Visa/Master cards. Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless we have a participating agreement with that company.

By signing below you acknowledge and consent to sections specifically indicated above: Consent for Treatment, Assignment of Benefits, Authorization to Disclose Medical Information for Payment and Payment agreement.

I understand and agree to the above statements.

X _____
Signature of Patient / Parent / Guardian

Date

Witness

Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have received and have been presented with the opportunity to review the Central DuPage Hospital Privacy Notice during this visit/prior visit. I understand that I may obtain a copy of any future revised Notices at any CD Hospital Registration site or on the Central DuPage Hospital Web site. (www.cdh.org)

X _____
Patient/Spouse/Nearest Relative/Legal Guardian **Date**

Reason that Notice was not accepted or patient/representative did not acknowledge receipt:

___ Patient indicates received on prior visit ___ Patient declined to sign
___ Other _____

_____ Patient/Representative initials if declined ___ Employees initials (if patient/representative did **not accept**)

AUTHORIZATION TO LEAVE MESSAGE

In completing and signing this form, I authorize that CDPG may leave a message containing medical information for a period of 12 months from the date signed on this form and as follows:

On my business/place of employment voice mail/answering machine Yes No
(Please Circle)

On my home voice mail/answering machine Yes No
(Please Circle)

On my cell phone voice mail # _____ Yes No
(Please Circle)

In the space below, if so desired, please indicate any personal *representatives/individuals who are permitted to receive or know information concerning your healthcare for the period 12 months from the date you sign this form. If your designated personal representatives change during the time this form is in effect, you must contact CDPG in writing and request the change.

_____ With an individual(s) I designate as follows: _____

* A personal representative as defined under the Health Insurance Portability Act of 1996 (HIPAA) is any family member, friend or individual designated by the patient to whom the patient's health information may be disclosed.

If you would like to change any of the information on this form, prior to the end of the time period stated above, you must contact CDPG in writing and request the change. This form must be up-to-date, signed and on file in your chart prior to any medical information being left on answering machines or with individuals you designate.

X _____
Patient Name/Spouse/Nearest Relative/Legal Guardian **Date**

Witness **Date**