MIDWESTERN UNIVERSITY

PATIENT AUTHORIZATION, ASSIGNMENT, AND ACKNOWLEDGMENT

Patient's Name: ____________________________ Patient's Account Number: ________________________

1. **PRIVACY NOTICE:** ________ (Initial) Midwestern University's Notice of Privacy Practices provides information about how Midwestern University may use and disclose my protected health information. I have been offered a copy of Midwestern University's Notice of Privacy Practices and have (initial one): ________ **Accepted** the copy, or ________ **Declined** the copy.

2. **AUTHORIZATION TO RELEASE INFORMATION:** _______ (Initial) I authorize Midwestern University to furnish requested information from my medical record to: (1) any insurance company, third-party payor, governmental agency, or workers' compensation carrier for the purpose of obtaining payment, and (2) any representatives of local, state, or federal agencies in accordance with law. Such information may include information concerning communicable diseases. I authorize the release of information from or the review of my medical record for the purpose of conducting any medical audits, utilization reviews, or quality assurance reviews. I further authorize Midwestern University to release information from or copies of my medical record to my referring physician or to any other health care facility or provider to which I may be transferred or referred. For care and treatment that I have paid for out-of-pocket, I acknowledge that I may make a written request to limit disclosure of certain records, except as otherwise required by applicable law.

3. **ASSIGNMENT OF INSURANCE BENEFITS:** ______ (Initial) In consideration of services rendered, I hereby transfer and assign to Midwestern University and to the licensed physicians, groups, or individuals who perform services for my care and treatment at Midwestern University, all of my right, title, and interest in any payment for services described herein as provided in any health insurance or similar policy or employee benefit plan. I understand that I am responsible for providing to Midwestern University all insurance information at the time of admission to allow for verification. I hereby certify that the insurance information that I have provided Midwestern University is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I understand that regardless of my assignment of insurance benefits, I remain personally responsible for the total charges of the services rendered.

4. **MEDICARE ASSIGNMENT OF BENEFITS:** _______ (Initial) I certify that the information I provided in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of information concerning me and any information needed for filing a Medicare claim to the Centers for Medicare and Medicaid Services (Medicare) or its Medicare Administrative Contractors. I request that payment of authorized benefits be made on my behalf and I assign my benefits payable to the physician or organization submitting a claim to Medicare for me. I understand that regardless of my assignment of Medicare authorized benefits and any subsequent reimbursement by Medicare, I remain responsible for any remaining balance due to Midwestern University and I agree to pay Midwestern University the remaining balance.

5. **APPOINTMENT OF REPRESENTATIVE AND JUDICIAL REVIEW:** _______ (Initial) I hereby appoint Midwestern University or the Clinic Operations Administrator or other representative as my duly authorized representative and assignee ("Representative") during any (1) administrative claims process; (2) appeal or review process for a denied claim; or (3) State or Federal legal process, necessary to collect claims submitted on my behalf, but denied on my plan. I hereby authorize the Representative to take all necessary actions to resolve any disputed claim for reimbursement for services provided to me by Midwestern University, including the filing of all necessary appeals and complaints with the proper authorities and the release of all information related to the services. If my claim for benefits is administratively denied in whole or in part, I hereby assign all causes of action for judicial review and/or appeal to my designated Representative. (This means that Midwestern University will arbitrate your claim for you.)

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6. **PATIENT RECEIPT OF PAYMENT:** ______ (Initial) I agree to immediately sign over and send directly to Midwestern University any funds that I receive from my insurance company in connection with services provided to me at Midwestern University. This is a direct assignment of my rights and benefits under my medical policy/plan. I understand this payment will not exceed my indebtedness to Midwestern University, and I agree to pay, in a timely manner, any balance of charges over and above the payments made to Midwestern University pursuant to this assignment of benefits.

7. **COLLECTION EFFORTS:** ______ (Initial) I authorize the release of any information pertinent to payment for services rendered to me by Midwestern University to any insurance company, adjuster, or attorney involved in Midwestern University's efforts to collect payment for services provided to me.

8. **DUPLICATION:** I permit a copy of this authorization, assignment, and acknowledgement to be used in place of the original.

9. **INSTRUCTION AND RESEARCH:** Your medical records may be used for purposes related to education, instruction, and/or research. Your medical records will be used for these purposes only after de-identification or as otherwise authorized by, and pursuant to, applicable regulation and law.

10. **RESPONSIBILITY FOR COSTS:** I acknowledge and agree that irrespective of any insurance coverage or the reasons for electing not to have a claim submitted to insurance for coverage, I am personally and fully liable for any and all costs related to the services received. To the extent that I am choosing not to have insurance cover the costs of services received, I do so voluntarily and I further understand that doing so is not a condition of or for treatment.

11. **PRIOR EXPRESS CONSENT:** As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a pre-recorded message. By providing your cell phone number, you consent to receiving such calls at this number. If you do not wish to receive these calls, please check the box that you wish to opt out ☐ and initial _________.

12. **NEW PATIENT BOOKLET:** I have been provided with a copy of the "New Patient Booklet." ☐ initial _______.

13. **E-MAILS:** Occasionally Midwestern sends out information to let patients know of events that may be of interest. These reminders are sent via e-mail. If you wish to opt out please check the box and initial ☐___________.

Patient Signature: ______________________________

Patient Printed Name: ______________________________

Patient Representative Signature (if applicable): ____________________

Patient Representative Name (if applicable): ____________________

Date: ______________________________

Relationship of Representative To Patient (if applicable): ____________________

Witness Signature: ____________________

Witness Name: ____________________

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