# Wheaton Franciscan Medical Group
## Physician Office Consent for Treatment & Financial Agreement

**A. Consent for Treatment:** I give my consent to my physician, other attending physicians and their assistants and designees, to provide me with such medical, surgical, diagnostic or other treatment services judged necessary and/or appropriate. This consent includes my consent, for diagnostic procedures and all medical treatment rendered at my physician's office under his or her instructions including x-ray and laboratory procedures and other tests, treatments or medication, monitoring, and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment, cells, tissues and/or parts may be removed from my body. I authorize my physician and his or her personnel to preserve or use such cells, tissues or parts for teaching purposes and/or to dispose of any cells, tissues or parts that are removed.

**B. General Acknowledgments:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury, and even death. No guarantees have been made to me with respect to the results of my examinations or treatments. I understand and agree that I may be observed and/or receive care from medical, nursing, and other health care students in training at my physician's office. I understand that it is my responsibility to follow instructions about and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place in my physician's office, during regular business hours. I authorize this health care provider to disclose any and all of my health care records to me, as allowed by law, on my verbal request during the duration of my treatment relationship with this health care provider for my own purposes, including, but not limited to, obtaining further medical care, insurance payments, disability determinations or legal investigations.

**C. Assignment and Agreement to Pay:** I understand that I am responsible for payment for the services that I receive and guarantee payment for these services. I hereby assign to Wheaton Franciscan Healthcare and to the physicians, for application to my bill for services, all of my rights and claims for reimbursement under any federal or state healthcare plan (including but not limited to Medicare or Medicaid), insurance policy, any managed care arrangement or any other similar third party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to me. In the event an insurer, health plan, Medicare, Medicaid or any other third party payer denies partial or total payment, I authorize the Facility to appeal the denial to such payer on my behalf. I further authorize the Facility to request a review of any denial to an independent or external review organization if such review is available through my health plan or applicable laws. I understand that I am responsible for any applicable co-payment, deductibles, co-insurance and/or non-covered costs and charges. I understand that not all insurance companies pay the usual and customary fees of physicians and/or the professionals associated with an office practice therefore, when permitted by law, any outstanding balance will be my responsibility. I understand and agree that I am responsible for the cost of collection and/or reasonable attorney fees related to my account. I understand that my health information will be released to my insurers, payers, or others for billing purposes. I also understand that I may receive separate bills from independent physicians involved in my care including radiologists, anesthesiologists, pathologists, emergency room physicians and other independent physicians. These physicians may or may not participate in all insurance networks. This Agreement covers care provided for a period of one year from this date.

**D. Photographing:** I understand and agree that the Facility may take photographic, electronic and/or video images of me in cases when it is required to assist with my treatment or for my safety.

**E. Privacy Notice:** I acknowledge that I was provided with a copy of the Notice of Privacy Practices. Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information. I hereby authorize WFMG to release information to other health care providers and school health offices through the Wisconsin Immunization Registry to facilitate completion of vaccine schedules.

**F. Document Authenticity:** I acknowledge that any changes or alterations to language contained in this document may prevent my services from occurring as this document is a non-negotiable condition of admission.

_____ _____ _____
Signature of Patient/Authorized Representative Date Time

_____
Relationship of Authorized Representative

If unable to sign document, state reason: _____

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Wheaton Franciscan Medical Group

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File: Pt Insur

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Name _____

Date of Birth_____

Chart ID_____