

## UNIVERSAL CONSENT FORM

**PATIENT NAME:** \_\_\_\_\_

**CONSENT FOR TREATMENT**

It is my wish to be treated by **Midwest Health Care Network** and its affiliated healthcare providers including: **Midwest Sports Medicine & Orthopaedic Surgical Specialists, Ltd; Open MRI Imaging Specialists, LLC; The Center for Physical Therapy at Midwest Sports Medicine and Midwest Center for Pain Management, Ltd. (hereinafter collectively referred to as "MHCN")**. I give permission for MHCN's physicians, physician assistants, chiropractic physicians and clinical employees caring for me to treat me in ways they judge will be beneficial. I further consent to any medication, examinations, X-rays, tests or minor procedures that my MHCN physician determines to be necessary. I understand my MHCN physician will explain to me the nature of my condition, his/her recommended treatment and any associated risks involved. I also understand that he/she will explain to me other ways this condition could be treated. I acknowledge that no guarantees have been made to me as to the diagnosis or result of examination or treatment in this facility.

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

I have been given an explanation and a copy of MHCN's "HIPAA Notice of Privacy Practices" and understand that I may call MHCN's Privacy Official if I have any questions regarding the content of this notice. I further understand that my medical record is considered privileged information and, as such, is protected by State and Federal laws. MHCN may use my information for purposes of treatment, payment and its operations as described in the notice of privacy practices.

I understand that, except as regulated by law, my medical record information will not be released should I refuse to sign this form. Therefore, I may be financially responsible for all costs incurred by me for treatment if a revocation or refusal to disclose information results in payment denial of my insurance claim.

**ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT**

I hereby authorize payment to Midwest Health Care Network and its physicians (who agree to accept this assignment) and assign all of my rights and claims for reimbursement of expenses allowable under Medicare, Medicaid, Workers Compensation, or any other health plans under which I may be entitled to reimbursement. I understand that I am financially responsible to MHCN for charges not covered by my insurance and this assignment.

In consideration of medical services provided by MHCN to the above-identified patient, I agree to pay to MHCN all applicable fees and charges. In the event that this obligation remains unpaid and requires referral for collection, I agree to pay all costs of collection and/or reasonable attorney fees. I hereby authorize my attorney to pay MHCN any outstanding balances due immediately upon receipt of any Workers' Compensation and/or Third Party Insurance Case settlement.

**DISCLOSURE OF OWNERSHIP**

MHCN is required to inform you that several of our physicians are investors in Midwest Sports Medicine & Orthopaedic Surgical Specialists, Open MRI Imaging Specialists, The Center for Physical Therapy at Midwest Sports Medicine and Midwest Center for Pain Management.

**Medicare Certification and Authorization:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I have provided, as appropriate, the information related to Medicare as a secondary payor as it applies to my Medicare health care insurance.

X \_\_\_\_\_  
Initials of Guarantor / Patient

**Sharing Of Medical Information:** I hereby authorize MHCN to share my registration, medical history, billing, insurance information, etc. within its own network. The sharing of information should avoid having you complete an identical form a second time and allow our staff to pre-approve tests or procedures more quickly, thereby expediting your medical care when utilizing other services within MHCN.

X \_\_\_\_\_  
Initials of Guarantor / Patient

**I have read and understand the above information and agree to its content:**

\_\_\_\_\_  
Signature (Patient/Parent/Legal Guardian) \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guarantor (if other than above) \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness: \_\_\_\_\_  
Date