SIU MEDICINE

SIU Consent to Treat, Billing/Collection Policy and Procedures & Notice of Privacy Practices Acknowledgement Form

CONSENT TO TREATMENT

I hereby consent to the treatment as determined necessary by SIU Physicians & Surgeons, Inc. and the School of Medicine, (collectively referred to in this consent form as SIU) who may care for me, their associates, assistants, students, interns, residents, fellows, healthcare professionals responsible for my care, to provide medical care, tests, procedures, (including but not limited to, intravenous (IV) catheter placement, urinary catheter placement, medications, services and supplies considered advisable by my provider(s). These services may include, but are not limited to, injections, minor skin surgery, vaccinations, skin tag/mole removal, and/or incision and drainage. I understand and authorize film or photography as necessary for my medical care and treatment. (A separate consent will need to be filled out if photos are used for educational purposes). I further authorize the examination, use and/or disposal, in any manner, of any tissue, fluids or parts removed from my body. I acknowledge and understand SIU Medicine is part of an academic medical center and as such medical students, interns, residents and fellows may be involved in my care and treatment.

Guidelines for the collection of clinical charges are essential in ensuring that we have the necessary financial resources to serve our patients. Privacy of personal health information is essential to assure your trust. Our policies in these two areas are listed below and in the Notice of Privacy Practices given to all patients.

MEDICARE/TRICARE/VA BENEFITS AND OTHER INSURANCE CLAIM FILING

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of medical or other information to the Social Security Administration or its intermediaries or carriers concerning this or a Medicare claim filed by SIU Medicine. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for Part A&B deductible for each year, the remaining co-insurance and any other non-covered charges. I (or my representative) certify(ies) that I or he/she has read (or if unable to read has had the form read to him/her) and understand(s) and accept(s) the above and further certify(ies) that I am the patient, or I am duly authorized on behalf of the patient to execute such an agreement.

We will bill your insurance in accordance with the insurance information you have provided.

If we do not have this information, you will be responsible for your bill. If you need additional assistance, the Business Office can provide any other necessary forms once your bill has been paid.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of insurance benefits otherwise payable to me, directly to SIU as the provider of services rendered not to exceed the charges not covered by this authorization. It is further agreed that any credit balance resulting from my overpayment may be applied to other balances.

After your insurance has adjudicated your claim, you will receive an itemized **statement** listing the amount owed by you along with your itemized account charges, receipts, and credits. This statement combines services for all SIU providers.

PAYMENT

All charges are due and payable at time of service or upon receipt of the initial statement. Payments can be made by cash, check, MasterCard, Discover Card or VISA. Checks should be made **payable to SIU**. In making payment, regardless of source, please include the lower portion of your statement to ensure that your payment is credited properly.

FINANCE CHARGES

We reserve the right to charge one if any part of your account balance is unpaid **90 Days** after the initial billing. The Finance Charge will be an amount equal to a periodic rate of 1% Per Month (Annual Percentage Rate of 12%) applied to any part of your account balance 90 Days and Older. The **Minimum Finance Charge** will be **Fifty Cents ($.50) Per Month.** The patient agrees to take all actions necessary to assist SIU in collecting payment(s).

YOUR BILLING RIGHTS

You have the right to examine and receive a reasonable explanation of your bill. We will provide a copy of an itemized bill upon request. You may contact us in writing or by phone if you would like an explanation of the bill for our services

STATEMENT OF PURPOSE OF SOCIAL SECURITY NUMBERS:
IDENTITY-PROTECTION POLICY:

The Identity Protection Act, 5 ILCS 179/1 *et seq.*, requires each local and state government agency to draft, approve, and implement an Identity-Protection Policy that includes a statement of the purpose or purposes for which the agency is collecting and using an individual's Social Security Number (SSN).

You are being asked for your SSN so that we may verify your identity and submit insurance claims to your insurer on your behalf. We may also be requested to provide your SSN to outside medical providers for similar purposes. We will only use your SSN for the purpose for which it was collected.

For further information and to view a copy of the SIU Board of Trustees Identity-Protection policy please go to the following link: www.bot.siu.edu and refer to the Identify-Protection Policy under the Policies tab on the home page.

RELEASE OF MEDICAL INFORMATION

I consent to the electronic storage and transmission of patient health information and the release of those records to myself at any time when requested. I acknowledge that there are instances when SIU must release information concerning my care, including information related to mental health, substance abuse (chemical dependency), HIV and/or AIDS, including copies of my medical records to certain individuals or entities who are involved in my care, payment for my care and other activities related to my care. Such disclosures are more fully described in the Notice of Privacy Practices and include disclosures to:

a. Any health professionals involved in my care for the purpose of facilitating the continuity of my care
b. Any person or entity responsible for, or any person or entity acting as an agent for the party responsible for payment, including third party payors, self-insurers, worker's compensation, carriers, and governmental agencies payment for the medical services rendered to me at SIU or any person providing services at SIU.
c. Any federal, state or other governmental or quasi-governmental agencies or other such parties as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
d. Any person participating in quality studies, utilization review, satisfaction surveys or similar studies of the care rendered by SIU and/or their providers.
e. Any continuing care, including but not limited to residential, long term care or home health agency for the purposes of obtaining and providing services for my care.
f. I also authorize my provider to obtain information from other providers regarding my care and treatment including obtaining my electronic medication and prescription history from whatever source for the purpose of my continuing care and treatment.
g. I acknowledge that my medical information may include Information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions, HIV or AIDs.
h. I acknowledge that I am aware of the Language Assistance Services Notice within SIU Clinics.

I also acknowledge that I have received a copy of SIU Notice of Privacy Practices.

I agree to receive auto-dialed and /or artificial or pre-recorded or any other type of messages, calls, texts, or emails from SIU and its employees, affiliates, contractors, and agents to any telephone number provided by me for, without limitation, appointment reminders, quality studies, utilization review, patient satisfaction surveys or similar studies regarding my medical care and treatment .

To opt out of any of the messages, calls, texts, or emails referenced above, I understand that I must notify the SIU front desk staff of my SIU provider and identify appointment reminders or the specific studies, reviews, or surveys that I no longer wish to receive. I understand that SIU will act upon my opt out request as soon as it is reasonably possible in the ordinary course of business.

SIU complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability or sex.

.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that I received the Notice of Privacy Practices of SIU, which sets forth the ways in which my **protected health information** may be used or disclosed and outlines my rights with respect to such information.

I have read, understand and agree to all of the information provided and I authorize treatment of the person named as "patient." I understand that SIU will file with my primary insurance company for services rendered and authorize payment of medical insurance benefits directly to SIU. I understand that I am responsible for paying any co-payment and deductibles that my insurance does not cover. I authorize SIU to obtain or release any information that is related to the treatment of the "patient."

Signature of Patient: Medical Record Number: Date:

If patient is not able to sign please provide reason (e.g.) minor. Reason: _____

_____

Signature of Patient Representative: Relationship to Patient: Date:

(Revised 3/2017)
(Revised/Approved by:QRS10/17/2018, OCP 12/12/2018 Q&S: 12/18/2018