FINANCIAL POLICY/ASSIGNMENT OF BENEFITS

It is the policy of Revitalize Medical Center to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If we do not participate in your network, you are expected to pay in full at time of service and we will provide you with the paperwork necessary to submit to your insurance company for possible reimbursement.

I understand that I am responsible for any co-insurance fees/charges, if it is not covered by a secondary. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to Revitalize Medical Center all surgical, medical insurance and other benefits, if any, otherwise payable to me for the services. If I receive direct payments from my insurance company, I agree to hold such payment(s) in trust for Revitalize Medical Center and agree to endorse over and send such payment(s) to Revitalize Medical Center within one week after receipt.

I hereby authorize direct payment directly to Revitalize Medical Center from the obligor of said benefits. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. Further, I hereby assign and convey Revitalize Medical Center, unless charges for the services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained, as well as any person obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for Revitalize Medical Center any settlement proceeds or other proceeds to be paid directly to me prior to receiving said proceeds.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appear to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further agree that, should my account with Revitalize Medical Center be turned over for collection purposes, I will pay an attorney and collection fee equal to an additional 30% of the balance owed and/or all the attorney fees and costs incurred to collect the unpaid debt.

HIPAA PRIVACY & RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize REVITALIZE MEDICAL CENTER, LLC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

REVITALIZE MEDICAL CENTER'S Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. REVITALIZE MEDICAL CENTER reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to REVITALIZE MEDICAL CENTER at 1787 Orchard Lane #8117, Northfield, IL 60093-3400.

With this consent, REVITALIZE MEDICAL CENTER may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out Treatment Payment and Operations ("TPO"), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, REVITALIZE MEDICAL CENTER may text message my cell phone with appointment reminders and patient statement balances.

With this consent, REVITALIZE MEDICAL CENTER may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, REVITALIZE MEDICAL CENTER may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that REVITALIZE MEDICAL CENTER restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to REVITALIZE MEDICAL CENTER'S use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, REVITALIZE MEDICAL CENTER may decline to provide treatment to me.

A photocopy of this assignment is to be considered as valid as the original.

HIPAA PRIVACY, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION AUTHORIZATION

I have read the above policies (or it has been read to me). I have had a chance to have all my questions answered to my satisfaction and understanding.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of and have read Revitalize Medical Center's Notice of Privacy Practices, Release of Billing Information policy, and Assignment of Benefits policy.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____
Patient/Legal Representative printed name

_____ _____
Patient/Legal Representative Signature Date

FINANCIAL POLICY AUTHORIZATION

I have read the above policies (or it has been read to me). I have had a chance to have all my questions answered to my satisfaction and understanding.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have read and been advised of Revitalize Medical Center's Financial Policy and Assignment of Benefits policy.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____
Patient/Legal Representative printed name

_____ _____
Patient/Legal Representative Signature Date

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____

Print Name

_____ _____

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.