SIU MEDICINE
FORWARD. FOR YOU.

SIU CONSENT TO TREAT & BILLING/COLLECTION POLICY AND PROCEDURES

CONSENT TO TREATMENT

I hereby consent to the treatment as determined necessary by SIU Physicians & Surgeons, Inc. and the SIU School of Medicine, (collectively referred to in this consent form as SIU). I authorize SIU providers and their staff, including, students, interns, residents, fellows, and other 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 recommended 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. I understand that my visit may be recorded for training and education 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. I acknowledge and understand that I may be treated by a healthcare provider of any gender, sexual orientation, ethnicity, religion or race. I understand that any Drug Enforcement Agency controlled substances are prescribed at the sole discretion of the provider in compliance with federal and state regulations and that I may be required to sign a controlled substances agreement if I receive such a prescription.

I may be offered the option of receiving care via telehealth. Telehealth involves the use of electronic communications to enable healthcare providers to care for me while I am at a different location. I understand that it is the provider's decision whether or not my needs are appropriate for a telehealth encounter. I understand that I will be billed for telehealth visits in accordance with federal and state regulations. I agree to follow the instructions given to me by SIU to ensure a successful telehealth visit. I agree that at no time during my visit, whether in person or via telehealth, will I photograph, video or audio record SIU providers or staff.

I understand that as part of the treatment SIU provides to me, SIU may release health information about me, including contact information, to SIU physicians and staff, SIU business associates, third party payers and other healthcare providers who may need this information for my care or for purposes of collecting money due from me. I agree that SIU's employees, business associates, and other third parties may contact me for any lawful purpose at any phone number or email address that I provide, including text/SMS, for which my telecommunications carrier may charge data usage fees (including additional charges when roaming), unless I expressly opt out. I understand that I can contact my wireless carrier for pricing details. I agree to be contacted by live operator, automatic telephone dialing systems, prerecorded message, text/SMS message or email. SIU may use phone numbers and email addresses that I provide or use to contact SIU or those which SIU obtains through other means. I understand that if I do not want to be contacted by phone call, text ISMS and/or email, I must (1) provide SIU with written notice revoking my prior consent, (2) include my name, mailing address and other identifying information, (3) identify whether I wish to have communications cease by phone call, text/SMS, email or all methods, (4) provide the specific phone numbers and email addresses, and (5) send the notice to SIU Medicine, PO Box 19639, Springfield, IL 62794-9639.

MEDICARE/TRICARENA 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. I understand that SIU will bill my insurance in accordance with the insurance information that I have provided. I understand that if I do not provide my insurance information, I will be responsible for my bill. I also understand that I will be responsible for the bill if I provide my insurance information after my insurance's timely filing deadline and my insurance has denied payment due to being processed past the timely filing deadline.

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.

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After SIU bills my insurance, I understand that I will receive an itemized statement listing the amount owed by me along with my 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
I agree to pay finance charges, costs of collection, late fees, and attorney fees if any part of my 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
I understand that I have the right to receive a reasonable explanation of my bill. SIU will provide me with a copy of an itemized bill upon request. I understand that I may contact SIU in writing or by phone if I would like an explanation of the bill for SIU 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 Theft Prevention policy please go to the following link: www.bot.siu.edu and refer to the Policies tab on the home page.

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 insurance providers 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.**

Signature of Patient _____ Date _____

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

Signature of Patient Representative _____ Relationship to Patient _____ Date _____