CENTRAL ILLINOIS HEARING, LTD. (CIH)

Consent for Medical Treatment and Release of Information

Patient Name: _____ Date of Birth: _____

1. **Consent for Health Care Services**: I authorize consent for medical treatment at Central Illinois Hearing.

2. **Authorization for Release of Information**: Central Illinois Hearing (CIH) may release information from my medical records to any health care provider involved in my care and treatment. CIH may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier any third-party payers. I acknowledge that upon the disclosure of medical record information to an insurance company, or other payer pursuant to this authorization, CIH is no longer responsible for the confidentiality of any information known or possessed by the payer.

3. **Educational:** I authorize Central Illinois Hearing, Ltd. to send me educational and/or marketing information on the products and services offered by Central Illinois Hearing, Ltd.

4. **Financial Agreement**: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by CIH which are not paid by my health insurance or other payer. I agree to promptly pay these charges upon receipt of the bill from CIH. I agree to pay all reasonable legal expenses (collection costs and attorney fees) necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with CIH. I understand that I am responsible for a $30 returned check fee.

5. **Pre-authorization Requirements**: I accept the responsibility to obtain all orders, referrals, or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan which I am relying on for medical coverage of Central Illinois Hearing charges. Central Illinois Hearing recommends you call for insurance benefits to verify coverage and to see if you have in or out-of-network benefits.

6. **Co-payments**: I understand and agree that I am responsible for all co-payments, which are due at the time of service.

7. **Assignment for Direct Payment**: I authorize that payment of any insurance (including auto insurance and healthcare insurance) benefits for health care services or goods be made directly to CIH.

8. **Quote of Benefits**: Any insurance quote given by our office staff does not guarantee payment.

I acknowledge that:

- I have read this form and understand its contents.
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I am responsible for the payment and/or co-payment that is due at the time of service.
- I may ask for a more complete copy of Central Illinois Hearing's HIPAA Policy (A copy is also posted in the waiting room.)

_____ _____

Signature of Patient or Legally Responsible Person | Name (please print)

_____ _____

Relationship/Reason Patient Unable to Sign | Date