Mercy and MercyCare Community Physicians

MEDICAL OFFICE CONSENT TO TREAT

CONSENT FOR MEDICAL TREATMENT

1. Knowing that I am suffering from a condition requiring medical care, I do voluntarily consent to such medical care encompassing diagnostic and therapeutic procedures and routine medical treatment by my attending physician or designees, as is necessary in his/her judgment, at Mercy Medical Center or a MercyCare Community Physicians clinic (together, "Mercy").
2. I am aware that some physicians on the staff of Mercy Medical Center, including the attending physician, are not employees or agents of the medical center but rather, are independent contractors who have been granted the privileges of using its facilities for the care and treatment of their patients.
3. I understand that, except in emergency or extraordinary circumstances, no substantial procedures will be performed upon me without the advice and order of a physician or other health professional and without my consent. I understand that I have the right to refuse consent to any medical or therapeutic procedure. Furthermore, I acknowledge that no guarantees have been made to me as to the result of examination or treatment at a Mercy location.
4. I authorize and direct Mercy to dispose of any tissues or parts surgically removed in accordance with accustomed practices.
5. I give my permission to be photographed, video or audio recorded for clinical, educational, or research purposes, as long as I am not directly identifiable.
6. I give my permission for video monitoring to be used to enhance my personal safety, or if medically indicated.
7. I give my permission to be photographed for identification purposes.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Mercy will disclose my protected health information to others only in accordance with its Notice of Privacy Practices and applicable law. Federal law and regulations and state law protect the confidentiality of alcohol and drug abuse patient records (42 USC §290dd-3, 42 USC§290ee-3 and 42 CFR Part 2 and Iowa Code Chapter 125) and state law protects the confidentiality of mental health information (Iowa Code Chapters 228 & 229) and HIV/AIDS information (Iowa Code Chapter 141A). I understand that any information regarding my care that relates to drug/alcohol abuse, mental health, or HIV/AIDS may be released to a third party only in accordance with applicable federal law and regulations and applicable state law. Your insurance plan may redisclose information with current and future treating entities related to this episode of care.

CONDITIONS OF TREATMENT

1. AGREEMENT TO GUARANTEE PAYMENT: I agree to guarantee payment for all charges resulting from services rendered by Mercy as requested by me, personally, or my attending physicians or designees, and to pay Mercy its charges at the prevailing rates and any balance due in excess of any amount paid by other persons or agencies. I understand that I am responsible for payment of all charges not covered by verified insurance and that such charges are due and payable upon discharge or at the time of service. By signature of this consent, you hereby authorize Mercy to apply any patient overpayments to any outstanding self-pay balances prior to sending a patient refund.

2. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of basic and major medical insurance benefits, otherwise due or payable to me or on my behalf, to Mercy and the physicians. I understand that I am personally responsible to Mercy for charges not covered by this assignment.

3. WIRELESS COMMUNICATIONS: By providing Mercy with my wireless / cell phone number and signing below, I am hereby granting Mercy, its agents or independent contractors, my consent to receive calls and text messages on my wireless / cell phone number for healthcare, billing, debt collection, and other purposes. I may be charged for such communications by my wireless carrier and such communications may be generated by an automated dialing system or play recorded messages. My receipt of healthcare treatment and services is not conditioned upon my consent to telephone communications. I may contact Mercy to provide notice of a change in my phone number or request that Mercy not contact me using any one or more methods or technologies by writing to Mercy at Central Billing Office, Mercy Medical Center 701 10th Street SE Cedar Rapids, IA 52403.

4. PATIENT'S CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST (FOR MEDICARE RECIPIENTS ONLY): I certify that the information given by me in applying for payment is accurate. I authorize Mercy to release to the Medicare Bureau, Centers for Medicare and Medicaid Services, or its intermediaries or carrier, any information relating to my treatment for processing this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

5. PHYSICIAN SERVICES: I understand that I will be responsible for the cost of professional services under the direction of my attending physicians rendering said service, as distinguished from charges for personnel and facilities rendered by Mercy. Such services may include but are not limited to pathology (Weland Clinical Laboratories, PC.), radiology (Radiology Consultants of Iowa, PLC, MR Associates), anesthesiology (Linn County Anesthesiologists, PC.), and emergency care (Linn County Emergency Medicine).

6. RESPONSIBILITY FOR PATIENT PERSONAL PROPERTY: Valuables should be left at home. Please do not leave valuables unattended. Mercy is not responsible for personal items.

I, the undersigned, certify that I have reviewed the contents of this form, the Consent for Medical Treatment, the Disclosure of Protected Health Information and the Conditions of Treatment, and I am satisfied that I understand its contents and significance.

Signature of Patient (or person authorized to sign for patient):

Date: May 5, 2021

If authorized signer, relationship to patient: