Blank Children's Hospital
UnityPoint Health

CONSENT TO TREAT
I request and give my consent to medical care and treatment from Blank Children's Pediatric Clinics providers and healthcare workers. I understand this includes and is not limited to diagnostic procedures, screening procedures, pathology services, and radiology services. I agree that photographs may be taken of me and used for my treatment or identification purposes.

HOSPITAL/OTHER FACILITY BASED CHARGES/BILLS
Laboratory specimens obtained in Blank Children's Pediatric Clinics will be processed by the Iowa Methodist Laboratory/Pathology Labs or as directed by your insurance. As the insured, you are responsible for contacting your insurance company to review your benefits for laboratory tests, x-rays or other services. Some insurance companies apply these charges to your outpatient deductible, not to an office visit. Therefore, you will receive a separate bill from the facility which performed the service/test. Your initials indicate you have been notified of this information. X __________

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
I understand that I am financially responsible to pay Blank Children's Pediatric Clinic its usual charges for all services received through Blank Children's Pediatric Clinic, including any balances not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Blank Children's Pediatric Clinic, and direct that payment of proceeds be made directly to Blank Children's Pediatric Clinic.

RECORDS RELEASE FOR CLAIMS PAYMENT
I authorize the release of medical record information or excerpts thereof to any insurance company or third party payer for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

My signature below represents I have read and understand the terms and statements above.
This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original

Patient Name (please print): ____________________________________ Date of Birth:______/_____/______

Patient Signature:____Date:______/_____/______

Parent/Guardian's Signature: ____

Relationship to patient: ____

ACKNOWLEDGMENT OF PRIVACY PRACTICES RECEIPT

☐ I have been given a brochure on Notice of Privacy Practices.
☐ I do not want a brochure on Notice of Privacy Practices.

____ ____________________
Patient/Parent/Guardian's Signature Date

Patient Label

Consent to Treat
Blank Children's Hospital Clinics