UnityPoint Health
Des Moines

**CONSENT TO TREAT**

I request and give my consent to medical care and treatment from UnityPoint Health – Des Moines 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.

**FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS**

I understand that I am financially responsible to pay UnityPoint Health – Des Moines its usual charges for all services received through UnityPoint Health – Des Moines, 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 UnityPoint Health – Des Moines, and direct that payment of proceeds be made directly to UnityPoint Health – Des Moines.

**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:

_____ _____
Patient or Guardian Signature Date

I **do not want** a brochure on Notice of Privacy Practices:

_____ _____
Patient or Guardian Signature Date