Consent Form

UnityPoint Health

CONSENT TO TREAT: I request and give my consent to medical care and treatment from UnityPoint Clinic 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.

TELEHEALTH AND ELECTRONIC COMMUNICATIONS: I consent to medical treatment and health-care related services being provided by remote telehealth technology, MyChart patient portal messages, and other electronic communication platforms. Such services involve a health care provider who is at a different location than me at the time of the service, and that such services often involve the transmission of video, audio, text, images, and other types of data. The remote health provider will determine whether my condition is appropriate for telehealth, MyChart patient portal message, or other electronic communications, and I understand that there is no guarantee of diagnosis, treatment, or prescription. I also understand that delays and disruptions in treatment may occur due to technical problems and problems with equipment, and that other risks include failures in security protections resulting in a possible breach of privacy and unauthorized access to my medical information.

Further, I understand that I may have to travel to see a health care provider in-person for diagnosis and treatment matters. I have the right to refuse treatment via telehealth-related technology or equipment without affecting my future care or treatment.

FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: I hereby certify that the information provided by me in order to apply for payment under Titles XVIII and XIX of the Social Security Act or by any third-party payors is correct. I assign payment to UnityPoint Clinic all benefits due to me under the terms of said policies and programs. I assign payment to the provider(s) rendering medical services and the provider(s) for whom the organization is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles, coinsurance/copayments or any other charges incurred which are not paid by my insurance or other third-party payors together with all costs of collection, if necessary, including a reasonable attorney's fee if collected by or through an attorney at law.

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.

CONSENT TO CONTACT: By providing a wireless and/or residential telephone number and/or an email address, I expressly consent to receiving live, autodialed and/or pre-recorded message calls, text messages and/or emails from UnityPoint Clinic and/or its affiliates, agents, contractors or business associates (including but not limited to third party debt collectors) at any phone number or email address, whether cellular, residential or other, associated with my account for any purpose (including but not limited to debt collection or payment) relating to the services provided by UnityPoint Clinic.

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