The medical professionals of Parkview Physicians Group are committed to providing you with quality, cost-effective healthcare delivered in a timely and compassionate manner. In order for Parkview Physicians Group to continue with our commitments to patients, quality and service please take a few moments to read and sign the following agreement. Thank you for choosing Parkview Physicians Group for your healthcare needs.

Financial Responsibility Agreement

1. I understand and agree that I am responsible for the payment of my (and/or my dependent's bill) for medical charges. I agree to pay all charges at the time of service unless Parkview Physicians Group, as a courtesy, agrees to file a claim with my insurance company or worker's compensation.
2. I understand Parkview Physicians Group currently files with most major insurance plans. However, Parkview Physicians Group cannot guarantee that the insurance plan accepts Parkview Physicians Group as a participating provider; therefore, may not pay all or any part of my bill. It is my responsibility to verify participating providers with my insurance company.
3. I understand charges for care provided to me will depend on what is wrong and what must be done to provide appropriate, quality medical care. If I received a charge estimate over the telephone, it was an attempt to provide me information I requested; but, because I had not been evaluated, such estimate is not a guaranteed price. In addition, all bills are subject to review by qualified billing and medical coding professionals, who may determine that additional charges or a refund may be due; thus, initial charges may not reflect my final bill.
4. If there is a balance due on my account and I have not paid according to the terms above, my account may be turned over to a collection agency to collect the balance. I understand I will be responsible for attorney fees and collection costs. If I have provided Parkview Health with my cell phone number, I agree that Parkview Health, its agents and contractors may contact me on that number using an automated telephone dialing system or prerecorded or artificial voice to discuss my account, including current and possible future services, customer service, billing and collections. I understand that providing my cell phone number is not required to receive services and that I may revoke this permission at any time by calling the Patient Accounting Department at 260-373-7770 or toll free at 855-814-0012.
5. In regard to treatment of minors, a divorced parent or legal guardian who accompanies a minor and gives permission for treatment is responsible for payment of the bill. This applies even if another parent/guardian has been determined by court settlement or judgment to be financially responsible. Both parents are jointly and severally responsible for payment of a minor's medical charges.

Authorization for Treatment and To Release Information

The signature on this form serves as authorization for medical treatment by the physician, physician's assistant, nurse practitioner, or clinical staff for the named patient.

This authorization also serves as permission to access your medication dispense history.

It also provides authorization for Parkview Physicians Group to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator, and/or other health benefit payor representatives in order to process health care claims incurred at this office or for utilization review for quality assurance.

This authorization also serves as permission to obtain a copy of your complete medical record from other physician practices or medical facilities.

A copy of this authorization may be used in place of the original in obtaining medical records. I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by a written withdrawal.

I understand that I am financially responsible to Parkview Physicians Group for any balance not covered by my insurance carrier.

PARKVIEW PHYSICIANS GROUP

RELEASE OF INFORMATION AND AUTHORIZATION FOR TREATMENT

Patient Name: _____

Patient ID Number: _____

Social Security Number: _____

Assignment of Benefits

I hereby assign and authorize my insurance benefits to be paid directly to Parkview Physicians Group.

I HAVE READ AND UNDERSTAND THIS ENTIRE AGREEMENT

Signature of Responsible Party: _____ Date: _____

Printed Name: _____

Medicare Patients:

As a Medicare patient I further authorize Parkview Physicians Group or other holder of medical or other information about me to release such information to the Security Administration and Health Care Financing Administration or its intermediaries or carrier, as needed, for this or any other Medicare claim. I permit a copy of this authorization to be used in place of the original, and for payment of medical insurance benefits either to myself or to the party who accepts assignment.

Furthermore, as a Medicare beneficiary, I understand that a part or all of the services provided by Parkview Physicians Group may be non-covered by Medicare, and if so, I accept responsibility for payment of the non-covered charges.

Signature of Patient: _____ Date: _____

Medigap/Medicare Supplement:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Parkview Physicians Group for any services furnished to me by Parkview Physicians Group. I authorize any holder of medical information about me to release to

(Medigap Insurer) _____ any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient: _____ Date: _____

PARKVIEW PHYSICIANS GROUP

RELEASE OF INFORMATION AND AUTHORIZATION FOR TREATMENT