Hansa Medical Groupe

Patient Name:_____ Date:_____

CONSENT FOR TREATMENT

I authorize and consent to the administration and performance of all tests, treatments, and services which maybe ordered by any physician or designated assistant of Hansa Medical Groupe, LLC.

Minors must be accompanied by a parent or legal guardian for medical care, except when the minor is seeking specific services for which Illinois State Law does not require an obtained parental consent, accompaniment or guidance.

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to Hansa Medical Groupe, LLC and/or any legal entity providing billing services to Hansa Medical Groupe, LLC, all my rights, title, and interest to medical reimbursement benefits under my insurance policy(s) as indicated below. If my insurance benefits are provided through an ERISA plan, (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all rights, title, and interest as beneficiary of the ERISA plan to Hansa Medical Groupe, LLC, with regard to my treatment and care by Hansa Medical Groupe, LLC

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT

I authorize Hansa Medical Groupe, LLC to release medical information or copies of my medical records to insurance companies, third party payers, or authorized agents including claims review organizations in order to process a claim for payment on my behalf. This information may be disseminated to any and all employers insurance companies or their representatives who may provide coverage for medical charges and to comply with the requirements of any Professional Review Organization. This authorization may be revoked by writing at any time.

PAYMENT AGREEMENT

I agree to hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient, to Hansa Medical Groupe, LLC. I understand this constitutes a direct undertaking by myself and is not conditioned or contingent upon payment of any such costs, charges, or expenses by any third party. Assignments of benefits of any insurance policy or medical reimbursement plan shall not be deemed as a waiver of the Provider's right to require payment directly from the undersigned. The Provider reserves its right to require such payment. In the event an obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection services, including but not limited to attorney's fees. If the undersigned is more than one person, every obligation hereunder shall be joint and several.

We accept cash or check. Our charges are usual and customary for our area, however does not include or relate to the membership fee. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless Hansa Medical Groupe, LLC has a participating agreement with that company.

By signing below, you acknowledge and consent to the sections specifically indicated above: Consent for Treatment, Assignment of Benefits, Authorization to Disclose Medical Information for Payment, and Payment Agreement.

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Witness Date