Patient Name: _____

EVERY PATIENT MUST SIGN THESE SECTIONS

Patient Insurance Coverage Responsibility Disclaimer and Authorization:
I understand that it is my responsibility to know whether Midwest Aortic & Vascular Institute, P.C. (MAVI) is currently an authorized provider according to my insurance contract. If for any reason my insurance contract is not valid or any fees are not covered by my insurance contract, I am responsible for payment of all charges. I also understand that MAVI is required by law and contract to collect from me, ON THE DATE OF SERVICE, any present co-payment amount required by my insurance contract.

I understand that I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing and specialists' appointments. If prior authorizations are required by my insurance contract for diagnostic testing and specialists' appointments, I realize that it is my responsibility to request a referral authorization from my provider. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the services performed.

I understand and agree that, if my employer, workman's compensation carrier, or my insurance plan does not pay in full, I will be responsible for payment for all charges. I also agree that, in the event of collection, I agree to pay all outstanding charges and costs of collection including reasonable attorney's fees. I authorize my insurance company to pay all benefits directly to MAVI and thereby agree to the release of relevant medical information to insurance carriers. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand and agree to the financial policy as stated above.

Initial: X ____

Authorization and Consent for Medical Treatment:
While I am here I permit the employees, the doctor, and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the provider will explain to me the nature of my condition, his/her recommended treatment and any associated risks. I also understand that this care may include diagnostic testing, examinations, medical and/or surgical treatment and that no guarantees have been made to me about the outcomes of this care. I consent to general treatment, medical procedures, records requests and medications prescribed by MAVI.

Initial: X ____

Authorization to Acquire Medication History:
I hereby give authorization to the physicians of MAVI to download my medication history as prescribed by other physicians. I understand that this will become part of my medical record at MAVI.

Initial: X ____

Acknowledgement of HIPAA Notice of Privacy Practices:
I acknowledge that I have received the HIPAA Notice of Privacy Practices and that it is my responsibility to read its content. I understand that MAVI may, at its discretion, change the terms and conditions of this notice. I understand the physicians and staff of MAVI will not discuss my health information with others unless I expressly authorize them to do so.

Initial: X ____

Office Policies: I acknowledge that I have received a copy of the MAVI office policies.

Initial: X ____

Medicare Patients *(all patients who have Medicare must initial this section):*
I request that payment of authorized Medicare benefits be made either to me or on my behalf to MAVI for any services furnished by MAVI. I authorize any medical information about me to be released to the Health Care Financing Administration and its agents as needed to determine these benefits or the benefits payable for related services.

Initial: X ____

Calls To My Home:
MAVI may need to call you regarding appointment reminders, clinical and/or business-related issues. I give MAVI permission to leave a message on my answering machine, cell phone, or my designee's regarding medical information or appointments if I am not available. Please check one of the following:

☐ DO NOT LEAVE A MESSAGE ☐ Leave a message on my machine/cell phone if there is no answer. **Initial: X ____**

Authorized phone number(s): _____

The following person may receive my health care messages: _____

Name **Phone**

Signature of Patient/Guardian/DPOA: X _____ Date_____