MERCYONE℠

Patient Information – Financial Consent

Patient Name: _____ DOB: _____

By providing my cell, landline or any other number(s), I expressly consent to receiving communications from MercyOne Central Iowa Clinics, its staff, its contractor, collection agents, and other, at any number I provide or that are later acquire for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto-dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose, including but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these number is not a condition of receiving healthcare services.

Assignment of Benefits/Release of Information

I hereby request payment of authorized benefits, including Medicare and Medicap benefits if I am a Medicare Beneficiary, be made directly to MercyOne Central Iowa Clinics for services rendered during my eligible coverage period. I hereby authorize the physician/provider and/or supplier to release any information required to determine the benefits and process these claims. I understand it is my responsibility to notify the organization of any changes to my health insurance coverage. I understand I may revoke this authorization at any time by sending a written notice to the office.

By signing this form, I understand that I am responsible for and agree to pay for any and all health care treatment and services provided.

_____ _____

Signature of Patient Date

_____

Signature of Legal Guardian of Financial Power of Attorney
(if patient is under 18 years of age or unable to sign)

_____

Printed name of Legal Guardian or Financial Power of Attorney