



Physician/Provider: _____

Patient Name: _____

MRN: _____

**OSF MEDICAL GROUP
ASSIGNMENT/RELEASE/AGREEMENT TO PAY**

Physician/Provider is a member of OSF Medical Group ("OSFMG"), a service of OSF Healthcare System which is comprised of various physician/provider practices. In consideration of the treatment of Patient as a patient by OSFMG, the person(s) signing this form below ("Undersigned") agree as follows:

I. Consent to Release Information for Billing.

The Undersigned authorizes OSFMG to:

- a. submit all medical charges to insurance companies or their administering entities, governmental agencies or their intermediaries, third party payers providing benefits to the Patient, and to third-party collectors, and
- b. release to such entities, and to physicians participating in the Patient's care, or their agents, all medical records or other information necessary to determine available benefits and to obtain payment for services rendered.

The Undersigned understands that:

- a. medical records disclosed may contain information relating to mental health, developmental disabilities, alcohol and drug abuse diagnosis and/or treatment, HIV/Aids test results and genetic information;
- b. the Patient or his/her authorized representative has the right to inspect and to obtain a copy of the information disclosed;
- c. this consent to release information is valid until the date one year following today's date;
- d. the Patient or his/her authorized representative has the right to revoke this consent to release information at any time, except to the extent that actions were taken in reliance thereon; and
- e. if the Patient or his/her authorized representative refuses to sign or revokes this consent to release information, OSFMG may not be able to release medical information which is necessary to process claims for insurance benefits, and that the Patient will be billed directly for these services.

II. Assignment of Benefits.

The Undersigned assigns to OSFMG all of Patient's claims and rights to payment under any insurance policy or health plan of which Patient is a beneficiary. The Undersigned consents to OSFMG and its agents taking whatever legal action is necessary to obtain payment under any policy of insurance or health plan or from any governmental agency or third party payer. The Undersigned authorizes the application of any overpayment to any unpaid bill of OSFMG for which the Patient is responsible that has not been paid in full at the time of overpayment.

III. Financial Agreement.

The Undersigned acknowledges that the OSF Charity Assistance Policy is available for review by me upon request. The Undersigned agrees to pay the rates set forth in OSFMG's Charge Master ("Price List") for all goods and services provided to the Patient not paid by insurance. The Price List is hereby incorporated by reference and made part of this Agreement. The Undersigned was given the opportunity to review the Price List and either reviewed the Price List or expressly declined to do so. Except as provided below and unless other arrangements have been agreed upon in writing between OSFMG and Patient or his/her authorized representative (or Patient's payer), (a) the Undersigned understands that payment must be received at the time services are rendered; and (b) the Undersigned agrees to pay on demand the balance of charges to the extent

not paid by the Patient's insurer or other third party payer(s) within 30 days from the date of first billing. However, if OSFMG has agreed to accept payment for services provided to the Patient from a payer, including the Medicare or Medicaid programs, a health maintenance organization (HMO) or a preferred provider (PPO), the foregoing provisions shall not apply, and the Undersigned will pay the amounts which are Patient's responsibility under those programs or agreements.

The Undersigned further agrees to pay all costs incurred in the collection of Patient's account(s), including collection agency fees, attorney's fees and costs of suit. The Undersigned understands that the Undersigned is entitled to receive an itemized statement of the Patient's account(s) upon request.

IV. Miscellaneous:

If the Undersigned is not the Patient, the Undersigned represents and warrants that the Undersigned has full legal authority to sign this Agreement on behalf of the Patient. **All individuals signing this Agreement as the Undersigned shall have joint and several liability for all amounts due hereunder unless expressly signing in a representative capacity on behalf of the Patient.** If the Undersigned fails to make any payment when due hereunder, OSFMG may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. This Agreement and the obligations, consents, and informational releases contained herein shall be binding upon the Patient's heirs, executors, and administrators. The deletion of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such deleted provisions were omitted.

Prior to signing this Agreement, I have been given the opportunity to review the OSFMG Notice of Privacy Practices. If this Notice changes at any time, I may obtain a copy from [the Office of Risk Management].

I have read and fully understand this Agreement. I understand that I am entitled to an exact copy of this Agreement.

Date: _____

Signature of Patient: _____

(Print Name): _____

Signature of Legal Representative: _____

(Print Name): _____

(Indicate Relationship): _____

Signature of Insured, if other than Patient: _____

(Indicate Relationship): _____

Signature of Witness: _____

(Print Name): _____