AUTHORIZATION FOR TREATMENT, CONSENT TO RELEASE OF INFORMATION, AND FINANCIAL AGREEMENT

Patient's Name: **Date of Birth:**

I. Authorization for Treatment. I authorize Midwest Spine & Brain Institute ("MSBI") to provide treatment of the person named above.

II. Consent and Authorization for Release of Information

A. **Release of Information**. I consent to the release and use by MSBI of medical and other information about me to the extent permitted by law to the following:

- To a health care provider being advised, consulted or referred to in connection with my treatment or care;
- To a health information exchange where my information may be shared with and accessed by other health care providers and health care related entities for purposes of treatment, payment, and the health care operations of the participating organizations;
- To a health plan, insurer, third party payor, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigations, or quality of care studies or reviews; and
- To a person or organization in connection with MSBI's health care operations. These operations may include, but are not limited to, interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, record management and other related activities.

B. **Record Locator/Patient Information Services**. I consent to MSBI accessing and/or querying health information about me and the location of my health records through a record locator service or patient information service.

C. **Medical Research**. I authorize MSBI to use medical and other information about me for purposes of medical research. I understand that I will not be identified in any presentation or publication of the research.

D. **Revocation**. I understand that this consent shall continue until I revoke it, which I may do at any time by giving written notice to MSBI.

III. Consent to Receive Electronic, Automated or Prerecorded Communications

By my signature below, I indicate my consent to receive electronic, automated and/or prerecorded phone calls and text messages from MSBI, or its business associates, regarding my health care (including but not limited to appointment and refill or medication reminders) via email, on my residential phone line and/or cellular phone. I understand that if I do not wish to receive such electronic, automated and/or prerecorded emails, phone calls and/or text messages, I may notify MSBI in wring at any time of such preference.

IV. Financial Agreement

A. I agree to pay all fees and charges associated with services I and/or any of my family members receive from MSBI, including any and all amounts which are not paid for by my insurance.

B. I authorize MSBI to directly bill my health plan or third-party payor for services rendered to me by or on behalf of MSBI, but acknowledge that MSBI is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third party payor. I authorize any third-party payor through which I may have benefits (including, if applicable, Medicare, Medigap, or Medicare Advantage) to make payment directly to MSBI for such services. I understand and agree that MSBI is not responsible for collecting third-party payments or negotiating disputed settlements on my behalf.

C. I understand and agree to the following:
   1. If I cannot make a payment when due, I should contact MSBI's business office to discuss a payment schedule.
   2. A finance charge of 6% will be made on all charges that are over 60 days old. The finance charge is an annual percentage rate which is applied to the over 60 day balance after deducting payments and credits appearing on the face of the monthly statement.
   3. MSBI may accept late payments, partial payments, or any payments marked as being payment in full or as being in settlement of any dispute without losing any of MSBI's rights under the law.
   4. A $20.00 fee will be charged for each insufficient funds check returned to MSBI.
   5. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree to pay MSBI's reasonable attorney's fees and other related expenses.
   6. If I discover an error or have a question about my bill, I may call MSBI at (651) 430-9884. Formal inquiries must be submitted in writing within 30 days of receiving the bill, and must be sent to Midwest Spine & Brain Institute, 1950 Northwestern Blvd Suite 102, Stillwater, MN 55082. Written correspondence must contain the following information:
      a. Patient name and account number;
      b. The dollar amount of the suspected error; and
      c. Description of the error or item requiring more information.

The undersigned hereby acknowledges to have read and agrees to the above financial credit and payment policies of Midwest Spine & Brain Institute.

Patient Name: **Date of Birth**:

Patient Signature: **Date**:

Relationship to Patient, if applicable: ______________________