Premiere General Medicine SC
911 N. Elm, Ste. 328, Hinsdale IL 60521
7270 W. College Dr., Ste. 102, Palos Heights IL 60463
Ph: (708) 603-5980 Fax: (708) 589-9059
www.PremiereGeneralMedicine.com

Nicholas Rizzo, MD, JD, FACP
Matthew Toman, MSN, FNP-C
Kristin Doyle, MSN, NP-C, CCRN
Phyllis Glazer, MA, LCPC
Janice Sabatini, LMT, MMP

Consent to Health Care

Consent to Treat: I consent to medical treatment (inpatient, outpatient and emergency department services), diagnostic procedures and administration of medications deemed necessary and appropriate to treat my condition or illness rendered to me at Premiere General Medicine SC (PGM). I understand that physicians, nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to their involvement in my care. I understand that a facial photograph for purposes of identification may be taken and placed in my electronic medical record. I consent to this if I cannot supply a photo ID myself.

Responsibility for Payment: In consideration of services to be rendered for care at PGM, I agree to pay for all services, facilities and supplies provided to me or the patient at the established rates, including any deductible, co- payment or charges not covered by third party payers. I understand that it is my responsibility to check with my insurance carrier to determine whether the costs associated with the services provided to me at PGM are covered and if applicable, whether PGM is considered in-network. If I am out of my insurance company's provider network, I understand that I may have a greater out-of-pocket cost. I acknowledge that a copy of my medical records may be requested for the purpose of payment. If I refuse to consent to the release of my records or later revoke my consent, I will be fully responsible for payment. I acknowledge that I may receive separate bills for hospital and physician services. Hospital services may include facility fees or lab tests. Physician services may include services provided by a physician who physically examines me or one who does not have direct contact with me. For instance, I may receive a charge for physician fees associated with a physician interpreting my laboratory tests or supervising laboratory services.

Assignment of Benefits: In consideration of those health care services rendered, I hereby assign to PGMSC and authorize direct payment to PGM and the treating physicians, any insurance, health plan or third-party benefits otherwise payable to me or on my behalf.

Medicare Payment and Assignment of Benefits (if applicable): I request that payment of authorized Medicare benefits be made on my behalf for hospital and physician services furnished to me and I assign such benefits to PGM and the physicians providing the services. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed for payment of such benefits. I have been supplied with the Message from Medicare informing me of my rights as a Medicare recipient.

Patient Information Use and Disclosure for Treatment, Payment and Health Care Operations Purposes: I acknowledge and agree that PGM may receive, use and disclose information concerning my care, my prescription medications and my health care coverage for treatment, payment and health care operations purposes including but not limited to the disclosures described in its Notice of Privacy Practices. I agree that, for these purposes, PGM, including its business associates, may contact me by telephone at any telephone number provided by me or associated with my record, including cell phone numbers, which could result in charges to me. PGM may also contact me for these purposes by sending text messages or e-mails, using the contact information I provide. Methods of contact may include, but are not limited to, using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. If I am an inpatient and require placement in another facility or other extended services, I consent to the release of my records to individuals at other facilities during the discharge planning process.

I have had the opportunity to read and fully understand this consent for its content and significance. I certify that the information given by me for purposes of applying for benefits and payment for this medical treatment is complete and accurate. I agree with the information contained in this consent and confirm that I am the patient or am authorized to sign on the patient's behalf.

Patient name: _____ Date: _____

Parent/Guardian name: _____

Parent/Guardian/Patient Signature: _____