Med Center Health

Consent, Assignment of Benefits & Financial Agreement

Consent to Diagnostic Tests, Medical Treatment and Procedures:
By signing below, I consent to my child receiving health care services at his/her school as deemed necessary and provided by practitioners and employees of Commonwealth Health Corporation, d/b/a Med Center Health, d/b/a Med Center Health School Based Clinic, and any other affiliated entity (herein after, Med Center Health). I understand Med Center Health may notify me if my child receives services, unless the child is emancipated or able to consent to his/her own treatment as permitted by Kentucky Revised Statute 214.185. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Assignment of Benefits and Financial Agreement:
I accept responsibility for the charges for the care provided to my child by Med Center Health. I agree to the assignment of all third-party benefits to Med Center Health and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by Med Center Health as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by Med Center Health in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason. This writing is intended to be the complete and exclusive statement of the terms and conditions regarding my assignment of benefits and supersedes all previous communications, representations or agreements, whether oral or written. Any terms or conditions proposed by me or on my behalf that differ from or are in addition to the terms of this agreement are rejected and shall not become part of this agreement.

Unless other payment arrangements are approved by Med Center Health, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

Contact Information:
I agree Med Center Health and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information:
I give permission for Med Center Health and its staff to communicate and confer with the school's health professional and my child's other health care providers about health care services received from Med Center Health.
I authorize the release of all or part of my child's records, including information stored in the Med Center Health's corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to my child. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my child's HIV test results to health care personnel in the event of an occupational exposure.

I authorize Med Center Health and any other holder of medical or other information to release information about my child (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to my child to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by Med Center Health to make collection of any unpaid charges. I further authorize my employer to release to Med Center Health or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Information Received:
_____ I acknowledge receipt of the NOTICE OF PRIVACY
(initial) PRACTICES.

_____ This consent will remain in effect for the entire school year in
(initial) which this consent was signed, or until it is revoked in writing and the revocation is received by Med Center Health.

I affirm I have the right as the parent or legal guardian of the minor child listed below to give consent for health care services on his/her behalf. I agree to notify Med Center Health of any change in my status as legal guardian.

Print name of minor child: _____

_____ _____ _____ _____
Signature *Date* *Time* *Relationship*

_____
Witness

CONSENT, ASSIGNMENT OF BENEFITS, & FINANCIAL AGREEMENT
14-780010 Rev 7/20

GENCOND