The Physician Network Consent to Treat & Financial Policy

Welcome to our office. We are committed to providing you with the best care possible. Please read this information about our financial and billing policies. If you do not have insurance, you must pay at the time of service or make other arrangements prior to your scheduled appointment. We accept cash, personal checks (with ID), MasterCard, Visa, Discover Card, or American Express.

If you have insurance coverage, we will file claims on your behalf. We need current, accurate insurance and policyholder information. By providing this information to us, you authorize any services furnished to you by our providers to be paid directly to The Physician Network. If your insurance requires co-payment, you must pay that amount at the time of service. You are responsible for paying for any services not covered by your insurance. Any deductible or co insurance is your responsibility. Prior balances must be paid at time of service unless prior payment arrangement has been authorized.

The Physician Network will send you a monthly statement from each clinic where services were provided. Payment is due upon receipt of the monthly billing statement. Even if you have insurance, **payment to us is your responsibility.**

It is necessary for you to know what benefits your insurance plan provides for you. Not all services provided are covered by every plan. Many insurance plans require you to use certain hospitals or doctors and may require pre-certification or referrals to a different facility. We are not responsible if you are sent to a facility that is not covered by your insurance. It is your responsibility to know which doctor or hospital your plan requires you to use.

If your medical care is the result of a work related injury, your claim will be sent to your employer. They may pay directly or forward to workers compensation carrier for payment. If the carrier information is available to us, we will bill the carrier directly. It is your responsibility to complete any necessary forms to allow us to release information to your employer or the workers compensation carrier.

If your medical care is the result of a motor vehicle accident or other third party liability accident, you will need to let us know at the time of service if the insurance claim should be sent to your private health insurance or if the claim needs to be sent to another insurance carrier. We will bill the liability carrier and allow 45 days for payment. You will be responsible for payment on any claims pending litigation or settlement. In the event a work comp, motor vehicle or third party liability bill is returned to us as unidentifiable or denied or the claim is pending litigation or settlement, we reserve the right to bill your medical insurance.

In the case of a divorce or other living arrangements, the custodial parent is responsible for all payments. The Physician Network is not involved in disagreements between the parties in these situations.

You may be billed by other physicians for professional services such as lab or radiology, or by entities such as Physicians Lab, Advanced Medical Imaging or others for medical services provided.

Accounts not paid in full within 30 days are considered past due. If you cannot make regular payments, please contact us. There is a charge for each returned check and we use a collection agency when necessary. It is your responsibility to contact us to discuss potential eligibility for The Physician Network or other financial assistance programs based on stipulated income requirements or to discuss payment arrangements.

If you have any questions about this information, please call our billing office at (402) 421-0904 or (800) 203-1517.

PLEASE TURN FORM OVER FOR SIGNATURES

Consent to Treat:

I,_____do hereby voluntarily consent to such diagnostic procedures, hospital care and medical, surgical, treatment by The Physician Network's physicians, physician assistants, nurse practitioners, physical therapists or physician's designees as is necessary in his/her judgment. I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this medical practice**.**

I understand that by providing my consent for treatment The Physician Network will obtain my medication history information electronically through a pharmacy health information exchange (e.g., Surescripts, E-Prescribe). Physicians and providers access the information to know what medications I am taking so they can treat me appropriately and avoid adverse drug reactions.

Communications Consent:

Communications Consent: By providing my cell, landline, or any other numbers(s), I expressly consent to receiving communications from The Physician Network, its staff, its contractors, collection agents, and others, at any number I provide or that are later acquired 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 numbers is not a condition of receiving healthcare services.

Pharmacy Health Information Exchange:

I consent to TPN Entity to obtain my medication history information electronically through a pharmacy health information exchange (e.g. Surescripts, E-Prescribe). Physicians and providers access the information to know what medications I am taking so that they can treat me appropriately and avoid adverse drug reactions.

By signing, I agree to comply with the policies contained in this document

Patient or Authorized Signature: _____

Relationship:_____**Date:** _____

For Medicare Patients Only

Medicare Authorization:
I request that payment of authorized Medicare benefits be made either to me, or, on my behalf, to The Physician Network for any services furnished to me by their physicians. I authorize my holder of medical information about me to release to the Centers for Medicaid and Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.
Secondary Insurance Benefits Authorization I hereby authorize payment of my Medigap and/or Secondary Insurance benefits to The Physician Network for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient or Authorized Signature: _____Relationship: _____Date: _____
(Signed once in a lifetime)

For Office Use Only: _____Practice Initials

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