

# GUNDERSEN HEALTH SYSTEM®

## Patient Authorization and Service Terms

### Patient Information:

\_\_\_\_\_  
Name - Last, First

\_\_\_\_\_  
Medical Record Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date of Service

**Authorization for Treatment:** I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or other Gundersen\* medical staff consider to be necessary. I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location, and I consent to such services. I understand that my medical care and treatment may be provided by physician assistants, nurses, and other health care providers. I have read and understand this Authorization for Treatment and understanding that no guarantee or assurance has been made as to the results that may be obtained.

**Medicare Authorization:** To the extent that I am eligible for Medicare benefits, by signing this form I certify that the information given by me in applying for payment under Title XVIII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

**Authorization to Release Medical Information\*\*:** I authorize Gundersen to release all medical information as necessary to:

All Payors\*\*\* for processing health care claims.

- The person(s) I designate as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account.
- Accrediting and quality organizations, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations.
- My other health care providers for treatment or payment purposes; and
- Gundersen entities for the purpose of providing information regarding the services and goods of Gundersen and/or its affiliates that may be of interest to me. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information in accordance with applicable law. Gundersen may not condition treatment, payment enrollment, or eligibility for benefits on my agreeing to this provision.
- I authorize Gundersen and my insurer(s) to share my past, current and future health, treatment, and account records about services I've received from Gundersen and other care providers as needed to manage or coordinate my care and to improve the quality of that care.

### **Authorization to Assign Benefits and Release Information to Gundersen:**

I authorize my Payor(s) to pay directly to Gundersen any benefits due under the terms of my health care plan(s), for services provided by Gundersen. I understand Gundersen reserves the right to refuse or accept assignment of medical benefits. If I am a Medicare beneficiary, I request payment of authorized Medicare benefits to me or Gundersen on my behalf for any services furnished. If my health care plan(s) will not allow direct payment to Gundersen or if Gundersen chooses not to accept assignment of medical benefits, I agree to pay Gundersen all health care payments I receive for services. I authorize Gundersen to contact my Payor(s) to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s) and for my Payor(s) to release such information to Gundersen.

**The following provisions apply if you are seeking care at a Critical Access Hospital on your date of service.**

### **Notice of On-Site Physician Coverage:**

This Critical Access Hospital may not have a physician in the facility 24 hours per day. To meet your needs if an emergency medical condition develops, a physician is on-call and readily available to come to the hospital.

**Rx Drug Packaging:** I accept non-safety closure lids on any medications dispensed through the emergency room or urgent care clinic for self-administration.

**Iowa – Physician Fee:** Pathology and radiology services are medical services performed or supervised by doctors, and the personnel and facilities are or may be furnished by the hospital for said services. Charges for such services are or may be collected, however, by the hospital on behalf of said doctors pursuant to an agreement between said doctors and the hospital, and from said charges I consent that an agreed sum will be retained by the hospital in accordance with an existing agreement between the doctor and the hospital.

I understand that I may receive separate bills from individual physicians for any services performed.

**Iowa - Visual Monitoring:** Visual monitoring may be used for patient safety.

## Service Terms

**Statement of Financial Responsibility:** I acknowledge I am responsible for all charges for services provided, including any amount not paid by my health care plan(s), other than billing terms and restrictions under a government program. I authorize Gundersen to apply any credit balance on my account to any amounts that I may owe to one or more Gundersen entities. This is a family purpose obligation and our marital assets as well as my individual assets shall be available to satisfy this obligation.

**Use of Phone:** I agree Gundersen Health System, its Affiliates, and its Business Associates (including third parties and third-party debt collectors) have my express permission to contact me for any purpose associated with my account, including wireless telephone number. I understand that this may include the use of automated dialing equipment, prerecorded voice, or text messages.

**Notice of Privacy Practices:** I acknowledge that I have been presented with the Gundersen Notice of Privacy Practices. I can request a paper copy during my visit.

**ATTENTION:** This is a legal document. Changes will not be accepted on this form. By signing this authorization, you understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on you signing this authorization. When the following information is used or disclosed by the authorized recipient, this information may be subject to re-disclosure and is no longer protected. You also have the right to inspect and receive a copy of the material to be disclosed.

*Copies of records may be obtained with reasonable notice and payment of copying cost.*

- **If the patient is 18 year of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:  
 **Legal Guardian or Conservator**       **Health Care Agent (*Health Care Power of Attorney*)**
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:  
 **Parent**       **Legal Guardian**

Signature

Signature Date

\* For purposes of this form, Gundersen refers to Gundersen Lutheran Health System, Inc., Gundersen Lutheran Administrative Services, Inc., Gundersen Lutheran Medical Center, Inc., Gundersen Clinic, Ltd., Tri-County Memorial Hospital, Inc., St. Joseph's Health Services, Inc., Memorial Hospital of Boscobel, Inc., Moundview Memorial Hospital and Clinics, Inc., Palmer Lutheran Health Center, Inc., Gundersen St. Elizabeth's Hospitals and Clinics, including employees and agents,

\*\*Medical information includes, but is not limited to, information related to psychologic, psychiatric, sickle cell anemia, HIV/AIDS, communicable diseases, genetic testing, and alcohol and drug abuse diagnosis and treatment if such information exists.

\*\*\*For purposes of this form, Payor(s) includes, but not limited to, insurance carriers, health-plan administrators, or other payors including the Centers for Medicare & Medicaid (CMS) and their agents or review agencies.