

SCAN TO:
Admin -> Registration Insurance Cards

Patient Information – Financial Consent

Patient Name: _____

DOB: _____

By providing my cell, landline or any other number(s), I expressly consent to receiving communications from Mercy Clinics, 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.

Assignment of Benefits/Release of Information

I hereby request payment of authorized benefits, including Medicare and Medigap benefits if I am a Medicare Beneficiary, be made directly to Mercy Clinics for services rendered during my eligible coverage period. I hereby authorize the physician/provider and/or supplier to release any information required to determine the benefits and process these claims. I understand it is my responsibility to notify the organization of any changes to my health insurance coverage. I understand I may revoke this authorization at any time by sending a written notice to the office.

By signing this form, I understand that I am responsible for and agree to pay for any and all health care treatment and services provided.

Signature of Patient

Date

Signature of Legal Guardian or Financial Power of Attorney
(if patient is under 18 years of age or unable to sign)

Printed name of Legal Guardian or Financial Power of Attorney