Consent Form

UnityPoint Health Meriter | PARTNER OF UWHealth

To keep you fully informed of your potential financial responsibility, we are providing the following notification.

This financial notification is for services rendered at _____ (Location)

by _____ (Provider Name).

Service/Procedure:	**Fee(s) or down payment due at time of service:**
_____	_____
_____	_____

Please check:

☐ **SERVICES THAT MAY NOT BE COVERED BY INSURANCE**

It is my responsibility to contact my insurance company regarding my benefits. I am aware that my insurance may not cover the service(s)/procedure(s) requested due to being a non-covered service/procedure, out of network, denied authorization, denied as not medically necessary or other reason indicated by my insurance plan. *If my insurance is considered out of network with UnityPoint Health-Meriter, I am aware that (1) UnityPoint Health-Meriter is out of network with my insurance, (2) UnityPoint Health-Meriter has redirected me to a provider in my network, and (3) I know that I will be fully responsible for charges denied as non-covered.* I have agreed to pay the fee/down payment at or before time of services. Failure to pay at time of service will result in service(s)/procedure(s) not being provided. The fee/down payment will be applied to the total charges accrued. My insurance will be billed, and I agree to be responsible for any charges not paid by my insurance.

☐ **SELF-PAY**

I have indicated that I do not currently have insurance coverage and agree to pay the fee/down payment at or before the time of services. Failure to pay at the time of service may result in the cancellation of my appointment. The fee/down payment will be applied to the total charges accrued. I agree to be responsible for payment in full for any services received.

☐ **COSMETIC**

All fees are due at or before the time of service. Failure to pay at time of service will result in the cancellation of my appointment. My insurance will not be billed.

☐ **DO NOT BILL INSURANCE**

I have requested that my insurance not be billed. All fees/down payments are due at or before time of service and will be applied to the total charges accrued.

PATIENT LABEL

This financial notification is given in good faith and may not include additional services provided during your visit, including but not limited to, lab/pathology or services not identified on the previous page.

☐ I agree to pay the fees/down payment indicated above and the remaining balance of the total fees accrued.

☐ I authorize the services to be performed.

☐ I understand that if I am readmitted to hospital for complications, I agree to pay for any fees incurred.

I have read and understood all information presented to me before signing this consent form.

_____	_____	☐ am
Patient's Signature	Date Time	☐ pm
_____	_____	
Signature of Person Legally Authorized to Consent for Patient	Printed Name of Person Legally Authorized to Consent for Patient	
_____	_____	
Reason for Signature of Person Other than Patient	Relationship to Patient	
_____	_____	
Signature of Interpreter (if applicable)	Printed Name of Interpreter (if applicable)	
_____	_____	
Signature of Witness	Printed Name of Witness	

PATIENT LABEL