INDEPENDENT PHYSICIANS OF WISCONSIN, LLC **PATIENT AGREEMENT**

GENERAL CONSENT TO RECEIVE CARE

I, the undersigned, for myself or a minor child or another person for whom I am responsible and have the authority to sign, herby consent to medical care and treatment as ordered by the physicians of Independent Physicians of Wisconsin, LLC. This consent included my consent for all inpatient and outpatient physician services, diagnostic procedures and medical treatment rendered under the general or specific instructions of my physician or his or her designee, including examination, imaging procedures and laboratory procedures and other test, treatments and medication, monitoring, EKGs, and all the procedures including invasive procedures, which do not require my specific informed consent.

HIPAA Written Acknowledgment of Receipt

I acknowledge that I was offered the written Notice of Privacy Practice from Independent Physicians of Wisconsin, LLC, dba West Bend Medical.

Print Patient's Name: ____ DOB_____________________________

Please Sign: ____ Date: _____________________________

RELEASE OF INFORMATION FOR BILLING PURPOSES

I hereby acknowledge and agree that Independent Physicians of Wisconsin, LLC may release to my insures, other payers or other person necessary for billing and related purpose, any information which may be needed for the purposes of billing, collection or payment of claims for services provided by Independent Physicians of Wisconsin, LLC and its physicians. This information may include my identity, medical and psychological emotional illness, development disabilities, treatment of alcohol or drug abuse, surgical procedures, progress notes, and all other information contained in patient care records, only to the extent that such records are needed for billing or collection or benefits due from any payer. I understand that I have the right upon request to inspect and receive a copy of all records being disclosed.

INSURANCE COVERAGE VERIFICATION POLICY

Please be aware that although we extend the courtesy of obtaining verification of benefits from your Insurance, we cannot accept responsibility for obtaining complete information regarding pre-existing conditions, policy limitations in or out of network co-payments or your individual deductible status. If your insurance company denies your bill because they require information from you we will bill you until you provide them with the necessary information. If you fail to provide them with the needed information you will be held responsible for the services provided.

ASSIGMENT OF INSURANCE BENEFITS/RESPONSIBILITY FOR PAYMENT

I hereby authorize and assign payment directly to Independent Physicians of Wisconsin, LLC and its physicians, all health care insurance and other benefits and payments otherwise payable to me for services rendered to me by Independent Physicians of Wisconsin, LLC and its physicians. I understand that I am financially responsible to Independent Physicians of Wisconsin, LLC for all amounts not paid by my insurance or other payer. I understand that it is my responsibility to obtain required referrals and determine the extent of my insurance coverage regarding services, in or out of network co-payments, place of services and providers. I expressly promise and agree to pay Independent Physicians of Wisconsin, LLC all such charges which are not paid by my insurance plan, PPO, HMO, or other coverage, in addition to co-payments and charges for services.

VALUABLES

I understand and agree that Independent Physicians of Wisconsin, LLC assumes no liability for any loss or damage to any money, jewelry, documents, furs, or other articles brought by me. No employee or other person is authorized to accept, suggest or recommend storage of such articles.

SURESCRIPTS AUTHORIZATION

I authorize Independent Physicians of Wisconsin, LLC and its affiliated providers to view my external prescription history via the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here and it may include prescriptions back in time for several years. My signature certifies that I read and understood the scope of my consent and that I authorize Independent Physicians of Wisconsin, LLC to obtain external prescription history.

____ ____

Signature of Patient/Responsible Party If Responsible Party, Relationship to Patient

Date Signed____ Witness____

MEDICARE ASSIGNMENT AND ACKNOWLEDGMENT

My signature below signifies that the information given to Independent Physicians of Wisconsin, LLC by me in applying for payments under Title 18 of the 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 intermediators or carriers any information needed for services provided under the agreement or related Medicare claim. I understand it is mandatory to notify Independent Physicians of Wisconsin, LLC of any other party that may responsible to pay for my treatment. I hereby request that payment of authorized benefits be made on my behalf to the physicians of Independent Physicians of Wisconsin, LLC.

____ ____

Signature of Patient/Responsible If Responsible Party, Relationship to Patient

____ ____

Date Signed Witness