

# IUPUI Health Services

## AUTHORIZATION FOR TREATMENT, NOTICE OF PRIVACY PRACTICES AND GUARANTEE OF PAYMENT

### *Initial Each Paragraph*

\_\_\_\_ **Treatment:** I authorize IUPUI Health Services (HS), its agents, and employees, their agents and employees (collectively referred to as "Healthcare Providers") to furnish medical care and services, including but not limited to, diagnostic tests, examinations, and other medical and/or surgical procedures, which is deemed necessary in the course of my care.

I understand that IUPUI HS is affiliated with the Indiana University School of Medicine, and I agree that student physicians in residency training and students in training to be physicians, nurses, and allied health personnel may assist in providing my care and that my medical records may be used for purposes of research, education and patient care.

\_\_\_\_ **Privacy Practice and Use of Information:** I understand that my medical record information will be kept confidential pursuant to applicable federal, state, and local laws. And that all personnel including employees, their agents, medical staff, and students in training are obligated and bound to provide privacy and confidentiality with regard to my treatment and medical record. I authorize release of medical record information to:

- third party payors (if applicable), for patient care purposes
- health care institutions, (for patient care purposes)
- physicians and other provider (for patient care purposes)
- Hospitals Medical Staff Office (for credentialing purposes)
- Employee Health Office (for hiring/training purposes)

Or others who may have me as a patient. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

\_\_\_\_ **Guarantee of Payment:** In consideration for providing medical care and services to the patient by IUPUI HS, I hereby guarantee payment in full of my account at the time of service, unless other arrangements are made. If none is so made, then payment shall be made in full within thirty (30) days from the date of service. The undersigned agrees that in the event of default in payment, this document shall be construed as a written contract for the payment of services and reasonable attorney's fee, allowable interest and reasonable costs of collection may be added to the amount due on the account.

I have read the above and have had the opportunity to ask questions. I understand my rights and obligations as described in this authorization.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name