Patient Name or Label | Date of Birth | MRN

Creighton UNIVERSITY Medical Center
Creighton Medical Associates

Consent to Treat/Financial Agreement

CONSENT TO TREATMENT

Creighton Medical Associates is composed of providers who are affiliated with the Creighton University School of Medicine. I (or the parent, legal guardian, or authorized representative of the patient) authorize you to provide reasonable and proper medical care.

TEACHING AND RESEARCH INSTITUTION

I understand that Creighton Medical Associates is affiliated with a teaching and research institution. I understand that students (medicine, nursing, etc), residents, and fellows participate with Creighton Medical Associates' physicians in the care of patients.

FINANCIAL RESPONSIBILITY

I agree that I am responsible for payment of all charges for health care services provided to me. If applicable, I understand that an insurance card is necessary to validate my coverage for each visit. If I do not have my card with me, I accept financial responsibility for all services provided to me by Creighton Medical Associates in the event that I am not covered for these services, and I understand that I will receive a bill for these services from Creighton Medical Associates. Some insurance policies require a written referral from my primary care physician for specialist services to be covered. If I do not have that referral, I accept financial responsibility for the services provided to me by specialists at Creighton Medical Associates.

ASSIGNMENT OF BENEFITS

I hereby assign to Creighton Medical Associates any insurance or other third-party benefits available for health care services provided to me. I understand that Creighton Medical Associates has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Creighton Medical Associates, I agree to forward to Creighton Medical Associates all health insurance and other third-party payments I receive, for said services, immediately upon receipt.

MEDICARE BENEFITS

I certify that the information given to apply for Medicare benefits is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, its intermediaries or carriers, any information needed for this or related Medicare claims. I request that authorized benefits be paid on my behalf.

I AGREE THAT THESE PROVISIONS WILL REMAIN IN EFFECT UNTIL I PROVIDE WRITTEN REVOCATION TO *CREIGHTON MEDICAL ASSOCIATES (CMA); ATTENTION CUSTOMER SERVICE; 2500 CALIFORNIA PLAZA OMAHA, NEBRASKA 68178* AND THAT CMA CAN RELY ON THIS CONSENT UNTIL WRITTEN REVOCATION IS RECEIVED.

Patient Signature _____ Date _____
(or parent, legal guardian or authorized representative)

Patient Name or Label **Date of Birth** **MRN**

Creighton UNIVERSITY Medical Center
Creighton Medical Associates

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned acknowledges receipt of Creighton University Medical Center's/Creighton Medical Associates' Notice of Privacy Practices.

Patient Signature _____ Date _____
(or parent, legal guardian or authorized representative)