BCDI
BLEEDING & CLOTTING DISORDERS INSTITUTE
THE BLOOD EXPERTS

AUTHORIZATION / RELEASE / AGREEMENT TO PAY

Michael D. Tarantino, MD, S.C.
Jonathan C. Roberts, MD
Maria Espanol, MD
Jessica Mistretta, DO

1. **Authorization for Medical Treatment.** I authorize my physician(s) and his/her designee(s), other individuals with privileges to provide services at BCDI, and their employees to provide medical services to me, including diagnostic tests and therapeutic procedures necessary for the diagnosis and treatment of my illness or condition. Treatment means the provision, coordination or management of your health care, including consultations between health care providers relating to your care and referrals for health care from one health care provider to another. I further authorize medical care, testing, and treatment as necessary in emergency situations to preserve my life and the health of persons involved in my care without first obtaining consent from me or my family. I understand that BCDI may be a teaching institution, providing clinical training opportunities for medical, nursing, and allied health student and residents. I consent to such students and residents being involved in my care and treatment and understand that they are not employees of my physician or BCDI.

2. **Release of Information for Billing.** I Authorize release to insurance companies or their administering entities, governmental agencies or their intermediaries, third party payers providing benefits to me, and to third-party collectors, copies of all medical record or other information necessary to determine available benefits and to obtain payment for services rendered to me during my current course of treatment at BCDI. I understand that: (a) my medical record may contain information relating to mental health, developmental disabilities, alcohol and/or drug abuse diagnosis and/or treatment, HIV/Aids test results and genetic information and I authorize the release of such medical records for the purpose of billing and collection; (b) I have the right to inspect and obtain a copy of the information disclosed; (c) this authorization is valid until the date one year following today's date; (d) I have the right to revoke this authorization at any point in time, except to the extent that actions were taken in reliance thereon; and (e) If I refuse to sign or revoke this authorization, BCDI may Bill may not be able to release medical information which is necessary to process claims for insurance benefits and I will be billed directly for these services.

3. **Assignment of Benefits.** I assign to BCDI all claims and rights to payment under any insurance policy or health plan of which patient is a beneficiary, and consent to whatever legal action BCDI and its agents determine appropriate to obtain payment. The undersigned authorize the application of any overpayment to any unpaid bill at BCDI for the patient for which the undersigned is responsible that has not been paid in full at the time of the overpayment.

4. **Agreement to Pay.** The Bleeding and Clotting Disorders Institute and Michael D. Tarantino, M.D., S.C. requires that co-pays be paid at the time of each visit. The State of Illinois Medical Practice Act requires us to collect co-pays for each visit for all patients, regardless of insurance type, for the exception of Medicare and the All Kids Program. If your condition requires immediate attention and you are unable to pay your copay at the time of your visit, we will ask that you send payment within 5 days after your appointment. For non-insured patients, a $150.00 payment is required at time of your appointment for all non-insured patients. This payment will be applied toward your initial visit. Payment options for remaining balances may be arranged with our Finance Office.

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A $25.00 fee will be charged for all returned NSF checks. Failure to pay your account in a timely manner may result in your account being turned over to an outside collection agency. If this should happen, an additional $75.00 administration fee will be added to your outstanding charges. Future visits may require a prior approval and are subject to being on a cash only basis.

I agree to pay the rates set forth in the BCDI Charge Master for all services, facilities and supplies provided to me and my dependents not paid by insurance within 30 days from the date of the first billing. I was given the opportunity to review the Charge master and either reviewed the Charge Master or expressly declined to do so.

5. **Personal Valuables.** I agree that BCDI is not liable for loss, theft, damage or destruction of any personal property on the premises including money, electronics, jewelry, glasses, dentures, hearing aids, and documents.

NOTICE TO THE UNDERSIGNED

Do not sign this document before you read it. This agreement is effective as of the date of my signature and applies to all services provided during the patient's current course of treatment. If the undersigned is not the patient, the undersigned represent and warrant that they have full legal authority to sign this Agreement on behalf of the patient.

I have read and fully understand this Agreement. I acknowledge receipt of a copy of this Agreement.

Patient or Legal Representative **Name**: Date:

Patient or Legal Representative **Signature**: Date: