UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_____ **Initials**

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision. I have been informed of the information in writing by my physician's office in advance of the date of my procedure.

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RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

_____ **Initials**

FINANCIAL AGREEMENT: I understand and agree to all of the following:

a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor.
b. No conditional payments accepted and payments with attempted conditions will be applied to any amounts owed.
c. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's provider, and I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
d. I am responsible to make sure insurance payments are processed and paid promptly to my physician, and for my prompt payment of any amounts owed to Unity that are deemed "Patient Responsibility" under my insurance contract (for those payors with which Unity is a participating provider or "in-network"). Otherwise, it is my responsibility if my insurance does not cover such services, or Unity is a non-participating provider or "out-of-network".
e. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.
f. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement and I agree to waive my right to a trial by jury.
g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts and the terms of this agreement shall remain binding.

TELEPHONE CONTACTS: I authorize Unity and its affiliates and agents to contact me at the phone numbers I have provided (whether such is a cell phone or a land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me. If a machine or voice mail is reached I understand a message may be left for me. (If you are receiving treatment from multiple Unity providers, it may result in multiple calls.)

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NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

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INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

_____ **Initials**

NOTICE OF NONDISCRIMINATION: Unity complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender identity.

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OTHER PROVIDERS: I understand in addition to the attending physician, other physicians, such as radiologists and pathologists, and other providers such as laboratories and other medical professionals, may be involved in my care, and may separately bill me for their services.

_____ **Initials**

PHOTO CONSENT: I consent to have my photographs taken by the provider or designated associate if required, and permit use of photographs for medical records, education, and lectures.

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CANCELLATIONS OR MISSED APPOINTMENTS: A fee may be charged for any appointments not cancelled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance.

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MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Unity or my treating physician on my behalf.

_____ **Initials**

Patient Name/Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____