**CookChildren's**

# CONSENT TO TREAT & FINANCIAL AUTHORIZATION

1. **Consent to Treat:** The undersigned consents to any examination or medical treatment, and/or services rendered to patient by the physician/provider or their associates which in the judgment of such practitioners are advisable during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained from any diagnosis or treatment.

2. **Assignment of Benefits/Insurance Requirements.** In consideration of goods and services rendered or to be rendered, I irrevocably assign and transfer to Cook Children's Physician Network (CCPN) all right, title and interest in all benefits/monies payable for goods and services. I understand that in the event CCPN files a claim on my behalf that the same does not impose any contractual obligation upon CCPN and that I remain responsible for instituting suit within the applicable statute of limitations. I authorize CCPN to appeal any denial. It is agreed that any condition, including, but not limited to, pre-certification, pre-authorization, or second opinions shall remain the sole responsibility of patient and/or the patient's family, legal guardian, representative or agent. I authorize the payors listed herein and any other payors to release any and all information requested and/or related to my claim(s) to CCPN.

3. **Financial Responsibility.** It is agreed that regardless of any and all assigned benefits/monies, I, as the designated responsible party, am responsible for the total charges for services rendered, and I agree that all amounts are due upon request and are payable to CCPN, and agree to pay for all charges incurred. If not a member of an insurance HMO or PPO, fees for services provided must be paid at the time they are rendered. It is agreed that should this account become delinquent and it becomes necessary for the account to be referred to any attorney or collection agency for collection or suit, I, as the designated responsible party or entity, shall pay all collection expenses. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND ACCEPTS THIS CONSENT TO TREAT & AUTHORIZATION AND IS THE PATIENT OR PARENT OF THE PATIENT(S) OR LEGALLY AUTHORIZED REPRESENTATIVE OF THE PATIENT(S):**

_______________________________________ _______________

Signature of Patient or Patient's Legally Authorized Representative Relationship

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Date