Mertz MFM Center

Pre-Certification & Financial Responsibility: I understand that my insurer may review anticipated courses of treatment from Mertz MFM Center. I understand that if the insurer determines that the treatment plan is medically necessary and issues certification, my benefits will be available according to my policy terms. *However, if certification is denied, benefits may be withheld*. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her referring physician. *I also understand that I may be financially responsible for any charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment, retrospectively determine that a service was inappropriate, or should the certification occur too late to be valid*. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and referring physician in advance of my appointment.

I have read, understood, and agreed to the above terms __________(Initials)

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to Mertz MFM Center all medical provider benefits payable and any related rights existing under my insurance policies. I authorize and direct the insurance company to pay all such benefits to Mertz MFM Center. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and Mertz MFM Center.

I have read, understood, and agreed to the above terms __________(Initials)

HIPAA Acknowledgement & Consent: I understand that I have certain rights under the Health Insurance Portability & Accountability Act (HIPAA) regarding my protected health information (PHI). I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow-up care among all providers who may be involved, obtain payment from designated third-party payers, and conduct normal health care operations such as quality assessments or evaluations.

I have read, understood, and agreed to the above terms __________(Initials)

Authorization to Release & Share Medical Information: I hereby authorize Mertz MFM Center to release a copy of my complete health records covering the entire treatment period during which I received services from Mertz MFM Center to your referring provider.

I further authorize Mertz MFM Center to share limited health information with family or friends as identified below, for the duration of my treatment, and up to one year thereafter, unless I rescind such permission in writing:

Name & Relation to Patient: (Print) ____

Name & Relation to Patient: (Print) ____

Name & Relation to Patient: (Print) ____

I have read, fully understand, and consent to the above information in its entirety. By using an electronic signature, I demonstrate my acceptance of the information above. My electronic signature is as legally binding as my handwritten signature.

Patient or Guardian (where applicable) Name: ____

Patient or Guardian (where applicable) Signature: ____

Date: ____