Trinity Medical WNY, PC

FINANCIAL AGREEMENT AND HIPAA CONSENT

AUTHORIZATION FOR PATIENT CARE: The undersigned patient and/or representative ("Undersigned") hereby grants permission to the employees of Trinity Medical, WNY to render routine patient care, and to carry out the orders of the patient's physician, consultants, associates, and assistants of the Undersigned's choice.

ASSIGNMENTS OF BENEFITS: The Undersigned hereby certifies that all insurance information reported to Trinity Medical, WNY and all clinical providers for your care include all available sources of coverage, and assigns to the facilities of Trinity Medical, WNY, sufficient monies from said insurance to pay for the patient's care and treatment. The Undersigned further understands that regardless of assignment of these benefits, the Undersigned is personally responsible for the total charges for services rendered, and further agrees that all amounts are due and payable upon demand. The Undersigned further agrees that Trinity Medical, WNY retain the right to transfer monies from any credit balance account in the Undersigned's name to any other accounts which may be due and payable by the Undersigned

FOR PATIENTS ENTITLED TO MEDICARE AND/OR MEDICAID BENEFITS: If applicable, I hereby irrevocably assign payment of Trinity Medical, WNY services and medical benefits applicable and otherwise payable to me to the designated Trinity Medical, WNY facilities and to all clinical providers providing care to me. I certify that the information provided in applying for payment under Title XVIII or XIX of the Social Security Act, is correct and request that payment of authorized benefits are made to the designated Trinity Medical, WNY facility and all clinical providers providing care on my behalf. The Undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration and Centers for Medicare and/or Medicaid Services (CMS) or its intermediaries or carriers, any information needed for this or a related Medicare or Medicaid claim. The Undersigned assigns the benefits payable for physician services to the physician or organization furnishing the services or authorizes such physician or organization to submit a claim to Medicare or Medicaid for payment.

FINANCIAL AGREEMENT: In consideration of the services to be rendered to the patient on this date and all future dates, the Undersigned personally guarantees to pay the account of the designated Trinity Medical, WNY facility/service in accordance with the rates and terms established for the services rendered. The Undersigned also agrees that Trinity Medical, WNY facilities and all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication. The undersigned has been informed that many of the physicians at the Trinity Medical, WNY facility are privately practicing independent physicians, NOT Trinity Medical, WNY employees. These physicians (such as x-ray, emergency room, cardiology, etc.) bill separately from Trinity Medical, WNY for their professional services. The undersigned also agrees that if the account remains delinquent and thereby requires the services of a collection agency and/or lawful authorities for collection, the Undersigned shall pay reasonable attorney's fees and collection expenses. The undersigned has been made aware that the Trinity Medical, WNY Healthcare Assistance Program allows persons to receive medically necessary services at no charge or reduced charge, if they are eligible, at Trinity Medical, WNY facilities.

RELEASE OF INFORMATION: The Undersigned hereby permits the Trinity Medical, WNY facilities and agencies, the workforce of such entities, and the members of the Trinity Medical, WNY various medical staff, to disclose the patient's personally identifiable information for purposes related to the patient's treatment, to obtain payment for the patient's treatment, and in the other circumstances listed in the Trinity Medical, WNYs Privacy Notice where federal law does not require my further Authorization. I hereby authorize and consent to release of all PHI; medical and personal information (including but not limited to my home phone, cell phone, work phone, address and email address) to the Trinity Medical, WNY facility and to any and all clinical providers responsible for my care: interpretation of test results; account billing and collection; payment posting and/or processing; or related healthcare functions. The Undersigned also grants permission to release medical information to other health care providers involved in the patient's care and to others involved in planning for the care of the patient. The Undersigned likewise grants permission for these parties to release appropriate medical information back to Trinity Medical, WNY.

USE OF INFORMATION WITHIN Trinity Medical, WNY: I understand that in order for Trinity Medical, WNY to effectively operate and to render appropriate health care, it may be necessary to use and review the patient's medical records and information retained at one or more of the facilities of Trinity Medical, WNY. I therefore authorize the use of the patient's medical information by appropriate personnel and medical staff members within Trinity Medical, WNY for purposes related to the patient's treatment, to obtain payment for the patient's treatment, and for the healthcare operations of Trinity Medical, WNY. Additionally, I understand that Trinity Medical, WNY will include the patient's name, location and general condition in its Patient Directories, such as a patient census.

PATIENT ACKNOWLEDGEMENT FOR COMMUNICATION VIA THE PORTAL CONSENT. The Patient Portal will help you communicate with doctors, nurses and other support staff, allow you to see portions of your health information and in the future access to more types of information and communications. **Do not use the Patient Portal for serious medical problems. For an Emergency please call 911.**

To be completed by the Patient or the Patient's/Client's/Resident's Legal Representative:

I hereby consent to the above and acknowledge that a copy of the Privacy Notice was made available to me.

Name of Patient

Signature of Patient or Legal Representative

Name of Legal Representative (if signed by Legal Representative)

Authority of Legal Representative (e.g., Healthcare Proxy,

(Guardian, Parent) Date Signed: _____/_____/_____

_____Time:_____

CERTIFICATION: The Undersigned certifies that the Undersigned has read this form, and is either the patient, or has legal authority on behalf of the patient to execute the above and accept its terms; and that all information provided is accurate and complete to the best of the Undersigned's knowledge.