AERO ANESTHESIA
CONSENT TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS, CONSENT FOR TREATMENT AND FINANCIAL OBLIGATION

Patient Name: _____ Address_____

(Please print) First Middle Initial Last _____

Date of Birth:_____ _____

1. **Consent for Treatment:** I, the undersigned, a patient of Aero Anesthesia, P.A., request and authorize my nurse anesthetist and, who he or she may designate as his or her associates or assistants or who he or she may refer me to, to administer such treatment as is medically necessary (hereinafter referred to singularly and collectively as "Aero Anesthesia Provider(s)"). I understand that I may see more than one Aero Anesthesia Provider(s) for my medical care. Therefore, I voluntarily consent to said evaluation, medical care, and treatment by the Aero Anesthesia Provider(s). This consent further applies to any and all such medical services, care, diagnostic procedures and/or medical treatment as my Aero Anesthesia Provider(s) deem reasonable and necessary, including, but not limited to testing, laboratory, pathology and radiology. All of the foregoing referenced health care and services shall be referred to generally throughout the rest of this document as ("My Health Care"). In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained by the appropriate Aero Anesthesia Provider(s).

2. **Release of Information:** I hereby authorize any Aero Anesthesia Provider(s) to release, transfer, provide access to, divulge, and furnish my private healthcare information and medical records, including, but not limited to, diagnosis, medical history, treatment history and/or plan, test and diagnostic results, prescriptions, and all billing, payment and collection information and records as follows:

a. to Aero Anesthesia employees, Aero Anesthesia Provider(s) and non-Aero Anesthesia healthcare providers to provide, coordinate, and/or managed My Health Care and related services; and

b. to my health insurance company, health maintenance organization, health care network, health care plan, Medicare, Medicaid, Medigap, Health Care Financing Administration/Center for Medicare/Medicaid, third party administrator of any such health care plans or companies, or other authorized agent of any such health care plans or companies which provide insurance coverage in whole or in part for My Health Care (hereinafter separately or collectively referred to as "Plan(s)"0 in order to obtain insurance payments, determine eligibility or coverage, coordinate benefits, adjudicate or subrogate health benefit claims, provide risk adjustment of amounts due, provide billing and collection services, manage claims, obtain payment under contract for reinsurance, process date for related healthcare, review medical necessity or coverage, and provide utilization review; and

c. to Aero Anesthesia's employees, agent or subcontractors to engage in billing and account collection activities in an effort to obtain payment from me and/or from any applicable Plan(s) for My Health Care.

3. **Payment:** I hereby authorize and direct any of the Plan(s) listed above to make payment directly to Aero Anesthesia on my behalf whenever possible.

4. **Contracted Plan(s):** If my Plan(s) is a contracted plan, i.e. HMO, PPO or Open Access product, I understand and agree that I am financially responsible for non-covered medical services, copayments, co-insurance, and deductibles as set forth in the provisions of my Plan(s).

5. **Assignment of Benefits:** In consideration for services provided, I hereby assign to Aero Anesthesia, the benefits due me covering My Health care costs and expenses otherwise payable to me, for the Plan(s), policy or policies I have in effect for Plan(s) coverage, insurance coverage and policy(s) named, whichever applicable.

6. **Financial Obligation for Aero Anesthesia:** I understand and agree that I am financially responsible for the payment of all charges, that are my responsibility, for My Health Care, unless waived by contractual agreements between Aero Anesthesia and my Plan(s) or insurer or if prohibited by state, federal laws or regulations. Aero Anesthesia cannot accept responsibility for collecting your insurance or Plan(s) claim if there is no contractual agreement between Aero Anesthesia and the Plan(s) or insurer.

7. **Collection Fees, Costs, and Venue:** In the event that it becomes necessary for Aero Anesthesia to employ the services of a collection agency or an attorney to pursue collection of my account, I agree to be responsible for the payment of such collection fees and costs, including but not limited to, reasonable attorney's fees, court costs, and service fees. Interest on my outstanding account shall accrue at the rate of 1.5% per month. Should Aero Anesthesia file a legal action to collect on my account, I hereby waive venue and agree that venue shall be appropriate in Johnson County, Kansas.

8. **Force and Effect:** I have read and understand the above provisions and agree to all terms and conditions as stated. A copy of this consent shall be as effective and valid as original. This consent and all provisions contained herein shall be in force without expiration or time limitation no matter whether I change my insurance coverage or Plan(s). I understand and agree that none of the provisions of this Consent in anyway seek to limit applicable Federal, State, and Local law, including, but not limited to the Health Insurance Portability and Accounting Act of 1996 ("HIPAA").

Patient Name:_____

Patient/Legal Guardian Signature_____Date_____