DAY KIMBALL MEDICAL GROUP, INC.

AUTHORIZATION FOR BASIC TREATMENT **Name:_____**

MR #:_____

INTRODUCTION:
This is an agreement between you and Day Kimball Healthcare (DKH). It contains your agreement to pay for all services you will receive from DKH. It also addresses the use of your medical records (and other information about "you", "your"), insurance benefits, and certain conditions in regard to your treatment. In consideration of receiving services, you agree as follows:

AUTHORIZATION TO PROVIDE BASIC TREATMENT AND CONDUCT BASIC AND ROUTINE DIAGNOSTIC PROCEDURES:
I authorize the performing of all routine examinations, treatments, and care provided to me under the general or specific instructions or direction of my physician.

Pursuant to Public Act 09-133, I understand that as part of the medical procedures or tests, I may be tested for HIV. I understand that HIV testing is voluntary and I can choose not to be tested for HIV or antibodies to HIV.

INFORMED CONSENT:
I understand that if I require an operation or any procedure involving a degree of risk requiring an informed consent, except in the event of emergency my own physician will discuss the risks, benefits, and alternatives and answer my questions. I am entitled to consent or refuse to consent.

RELEASE OF MEDICAL RECORDS AND OTHER INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS:
I authorize DKH to provide from its records any information and medical records including psychiatric, substance abuse, HIV related or other confidential information ("Confidential Information") requested by my insurance/managed care company, Medicare, Medicaid, Champus, or other third party payors, hospital agents or governmental agencies in connection with payment of my bill. I also authorize DKH and its agents to provide Confidential Information from my medical records to any utilization, managed care, and/or quality review organization affiliated with my insurer/payor or otherwise for use in utilization management. I further authorize DKH to provide Confidential Information to its case management personnel, including authorization to discuss my medical care with my physicians, and to other health providers and facilities involved in my continuing care. I also authorize the release of Confidential Information to state or federal agencies for authorized purposes.

I have been informed that my refusal to grant consent to release of information relating to psychiatric treatment will not jeopardize my right to obtain present or future treatment except where disclosure of the communication and record is necessary for treatment. I understand that if my refusal to provide authorization results in a refusal of my insurer, managed care company or the third party payor to pay DKH, I will personally be responsible for the bill or the unpaid portion of the bill.

ASSIGNMENT OF BENEFITS:
I authorize third party payors, including insurers, managed care companies, and Medicare or Medicaid and other governmental payors, to make payment directly to DKH. I understand that I am financially responsible for payment for services not covered by this authorization, and that I will pay all costs of collection of any delinquent balance including reasonable attorney's fees, which may be added to my account. I understand that my refusal to grant authorization to my third party payors will in no way jeopardize my right to obtain present or future treatment except where disclosure is necessary for treatment but understand that under such circumstances I will be responsible for paying my bill in full. Upon request, patients may receive copies of their charges.

PATIENT RIGHTS AND RESPONSIBILITIES AND NOTICE OF PRIVACY PRACTICES:
The DKH's Policy on Patient Rights and Responsibilities has been provided to me, and I agree to comply with such policy.

FINANCIAL AGREEMENT:
I understand I am responsible for payment of any charges and agree to pay DKH the regular rates or charges for all medical services rendered to me. If I am covered by a third party (for example, Blue Cross & Blue Shield or other insurance or

managed care, or a benefit program such as Medicare or Medicaid), then the third party may pay all or a part of DKH rates or charges. If so, I agree to pay those rates or charges that are not covered or paid by that third party, and to the extent permitted by law are properly payable by me, as soon as I receive a bill. If I do not pay my bill I agree to pay DKH any collection costs including attorney's fees, collection agency fees, and court costs. DKH reserves the right to accept periodic installment payments without waiving its rights to demand payment in full.

MEDICARE AND OTHER GOVERNMENTAL PROGRAMS:
I agree that the information I have given in applying for benefits under Medicare, Medicaid, Maternal or Child Health Services or other governmental programs is complete and accurate. DKH may give the appropriate state and/or federal agencies (including but not limited to, the State Department of Social Services and the federal Social Security Administration or its fiscal intermediaries), any information about me that I have that may be necessary to process claims for such payment. DKH doctors and allied health care providers treating me may make direct claims for payment.

I HAVE READ THIS PATIENT AGREEMENT, OR IT HAS BEEN READ TO ME, AND I UNDERSTAND IT, ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND I FREELY AGREE TO ALL OF THE TERMS AND CONDITIONS IN THE AGREEMENT THAT ARE APPLICABLE TO THE PATIENT EXCEPT THOSE SPECIFICALLY NOTED ABOVE BY ME AS NOT APPLYING.

_____
DATE:

X_____
SIGNATURE OF PATIENT

_____
PRINT PATIENT NAME:

_____ _____
SIGNATURE OF AUTHORIZED PERSONAL REPRESENTATIVE **RELATIONSHIP**

If a representative has signed for the patient, please state the relationship to the patient and the reason the patient did not sign:

Reason