PROPONENT MEDICAL GROUP, LTD.
2350 ROYAL BLVD., SUITE 500
ELGIN, ILLINOIS 60123

Authorization for Payment and Insurance Information
Consent for Release and Use of Confidential Information
Receipt of Notice of Privacy Practices Form

- I understand that payment and/or current insurance information is required at the time of service. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to Proponent Medical Group, LTD for services or treatments rendered. I understand that Proponent Medical Group, LTD does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I understand that I am responsible for charges not covered by my medical insurance plan(s). If my account exceeds 90 days without payment or arrangement, my account will be considered delinquent and can be subject to legal action and/or assignment to a collection agency.
- I acknowledge receipt of the practice's **Notice of Privacy Practices**. The Notice of Privacy Practices provided detailed information about how the practice may use and disclose my confidential information.
- I hereby give my consent to Proponent Medical Group, LTD to use or disclose, for the purpose of carrying out **treatment, payment, or health care operations (TPO)**, all the information contained in the patient records as described below.
- I voluntarily give my consent for Proponent Medical Group, LTD to discuss my medical and/or payment information with the following people on my behalf:

NAME	RELATION	DATE OF BIRTH

I voluntarily give my consent for Proponent Medical Group, LTD. to leave a detailed message (i.e. regarding medical results, billing, medications, etc) **on my voicemail / answering machine as indicated below.**

Home:	_____	**Yes**	**No**
Cell:	_____	**Yes**	**No**
Work:	_____	**Yes**	**No**

I understand that the practice has reserve a right to change its' privacy practices that are described in the Notice. I also understand that a copy of a revised Notice will be provided to me or made available upon request or at the time of a subsequent office visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the practice. I also understand that I will not be able to revoke this consent in cases where the practice has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Proponent Medical Group, LTD.

Patient Name: (Please Print Clearly)_____

Signature: _____ **Date**: _____

Relationship: Self/Patient Parent Guardian POA **If other than patient, please print name here:**

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