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MAYO CLINIC

Authorizations and Service Terms

Form content retained in medical record.
Route to HIMS Scanning.

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*	
Birth Date *(mm-dd-yyyy)*	Room Number (if applicable)
Mayo Clinic Number	

TO BE SCANNED

Authorizations

Authorization for Treatment: I consent to the rendering of medical care which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or other Mayo Clinic* (Mayo) medical staff consider to be necessary. I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location. I consent to initiating and/or receiving technology-based communications with my providers, including consulting services from a specialist performed virtually. I agree to be responsible for any charges that insurance does not pay. I understand that my medical care and treatment may be provided by physicians, including fellows and residents, medical and allied health students, physician assistants, nurses and other health care providers. I have read and understand this Authorization for Treatment and understand that no guarantee or assurance has been made as to the results that may be obtained.

Authorization to Use and Disclose Medical Information**: I consent that as a Mayo patient, my Medical Information will be used, processed, and disclosed in accordance with U.S. law and as outlined in Mayo Clinic's Notice of Privacy Practices (mayoclinic.org/npp). Furthermore, I authorize Mayo to use, process, or disclose my Medical Information:

- To provide me with treatment and to coordinate my care;
- To bill for and collect payment for services, which may include communications to my Payer(s)*** and Billing Addressee/Guarantor;
- For health care operations as described in the Mayo Clinic Notice of Privacy Practices;
- For Mayo and my insurer(s) to share my past, current, and future health, treatment and account records about services I have received from Mayo and other care providers as needed to manage or coordinate my care and improve the quality of that care;
- To accrediting and quality organizations, regulatory agencies, and public health reporting agencies;
- To participate in health record locator services/health information exchanges (HIE) that allow Mayo, my health care providers, insurers and other third parties to electronically access and share my Medical Information via the HIE unless I opt out. If I opt out, by checking the box below, Mayo will exclude my Mayo Medical Information from the HIEs in which Mayo participates.

☐ **HIE Opt Out**

Authorization to Assign Benefits and Release Information: I authorize my Payer(s) to pay directly to Mayo any benefits due under the terms of my health care plan(s), for services provided by Mayo. I understand Mayo reserves the right to refuse or accept assignment of medical benefits. If my health care plan(s) will not allow direct payment to Mayo or if Mayo chooses not to accept assignment of medical benefits, I agree to pay Mayo all health care payments I receive for services. I authorize Mayo to contact my Payer(s) to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s) and for my Payer(s) to release such information to Mayo. I hereby give Mayo authorization to appeal on my behalf for services provided at Mayo. I understand that this may waive my insurance appeal rights as a member when appealing the insurance denial. By signing this form, I understand that future appeal and adjudication rights for services may be exhausted according to the provisions of my plan.

Service Terms

Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided, including any amount not paid by my health care plan(s), or an out of state workers' compensation payer, other than billing terms and restrictions under a government program or as prescribed by law in the state where medical services are provided. I authorize Mayo to apply any credit balance on my account to any amounts that I may owe to one or more Mayo entities. I agree that Mayo may obtain financial information, including consumer credit reports to determine eligibility for financial assistance and/or payment options. Information on financial assistance is available by calling 844-217-9591, or at mayoclinic.org or mayoclinichealthsystem.org.

Dispute Resolution: I agree that any dispute (including personal injury claims) related to health care services rendered by Mayo is subject to the exclusive jurisdiction of the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered and the law of that state. Any state court action must be venued in the county where the provider of the disputed services is physically located when the services are rendered. These agreements also apply to my legal representatives and next of kin.

Calling/Texting/Emailing: I agree that Mayo may use an automated phone dialing system, pre-recorded or synthetic voice messages, texting, and email to contact me at the numbers and email addresses I provide. I understand that I may be contacted regarding my health care. This may include, but is not limited to, appointment reminders, discharge planning, billing, prescription reminders, research opportunities, and/or to provide regulatory notice in lieu of first class mail. I understand that when contacted in this manner, I will be given the opportunity to opt out of similar future communications. To learn more about opting out, visit mayoclinic.org/npp.

Notice of Privacy Practices: I acknowledge I have been presented with the Mayo Notice of Privacy Practices, which can be viewed at: mayoclinic.org/npp. I can request a paper copy during my visit or by contacting the Privacy Office.

Signature

Attention: This is a legal document. Changes will not be accepted on this form. Questions or requests for alterations must be made by calling 507-284-3350. By signing, I agree that I understand and accept the terms on this form. I understand I have the right to revoke the authorizations on this form at any time by notifying Mayo in writing, except to the extent that Mayo has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Indicate your legal authority and include documentation of your relationship:
  ☐ **Legal Guardian or Conservator** ☐ **Health Care Agent (Health Care Power of Attorney)** ☐ **Other Legal Representative**
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Indicate your relationship: ☐ **Parent** ☐ **Legal Guardian**

Signature (required) ▶ Signature Required	Date *(mm-dd-yyyy)*	Time *(hh:mm)* ☐ am ☐ pm
Printed Name of Person Signing (if not patient) *(First, Middle, Last)*		

* For purposes of this form, Mayo refers to Mayo Clinic in Arizona, Florida, Rochester, Mayo Clinic Health System and all affiliated clinics, hospitals, and entities, including employees, business associates, and agents.

** Medical information includes, but is not limited to, photographs taken for identification purposes, information related to psychologic, psychiatric, sickle cell anemia, HIV/AIDS, communicable diseases, genetic testing, and alcohol and drug abuse diagnosis and treatment.

*** For purposes of this form, Payer(s) includes, but is not limited to, insurance carriers, health-plan administrators, or any other payers including the Centers for Medicare & Medicaid (CMS) and their agents or review agencies.

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.

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