

MCLEAN COUNTY NEUROLOGY, SC  
2204 EASTLAND DRIVE  
BLOOMINGTON, ILLINOIS 61704  
TEL: (309) 662-9461

Do you have a living will?  Yes  No

Copy in chart?  Yes  No

Do you have a healthcare power of attorney?  Yes  No

Copy in chart?  Yes  No

Name of Power of Attorney: \_\_\_\_\_ Phone # \_\_\_\_\_

**CONSENT FOR TREATMENT, RELEASE OF INFORMATION. RESPONSIBILITY OF PAYMENT**

**Consent to Medical Treatment**

I hereby consent for medical treatment and diagnostic procedures as may be deemed advisable for the course of treatment by my physician. I acknowledge that no guarantees have been made to me as to the result of examination or treatment. I understand that the physician may request assistance from medically trained individuals who may be employees or agents of this facility. I understand that authorized medical, nursing, and allied health professionals who are not employees of this facility may accompany and/or participate with the physician and staff in the observation and delivery of care and I consent to such participation.

**Release of Information**

I understand that my protected health information may be released to substantiate claims as outlined in the Privacy Notice provided to me by McLean County Neurology, S.C.  
McLean County Neurology, S.C. has the right to appeal any denial that may be made by my insurance company and has the right to receive complete documentation regarding any denials.

**Responsibility of Payment**

I understand that I am responsible for payment of services rendered by McLean County Neurology, S.C. regardless of any liability claims, insurance, lack of insurance, or insurance plan limitations. Such limitations may include, but are not limited to, pre-authorization or pre-certification programs, medical necessity limitations, and increased deductible or co-insurance amounts. I further agree to pay my account in full within 45 days from the date of first billing unless alternate satisfactory arrangements are made with McLean County Neurology, S.C.

I certify that I understand the content and significance of this form. My signature shall be in effect for one year from the date on this form.

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed: \_\_\_\_\_

Office use: Billing and Payment brochure given: Date: \_\_\_\_\_ Initials: \_\_\_\_\_