BELOIT HEALTH SYSTEM, INC.
PREAUTHORIZATION AND CONSENT TO TREAT MINORS ENROLLED WITH THE SCHOOL DISTRICT OF BELOIT

PURPOSE
This form may be used to allow minors who are School District of Beloit students to receive health care services from Beloit Health Services, Inc. ("BHS") at the Beloit School Clinic, located at Beloit Memorial High School, or other BHS locations. For some families, we understand that it may be more convenient to have prior authorization in place that allows health care services to be delivered to minors if a parent or legal guardian cannot be present to provide consent. If you would like to have such a preauthorization in place, please review and complete the following form authorizing health care services for your minor child in advance.

PREAUTHORIZATION AND CONSENT TO TREAT
I have the legal right to preauthorize BHS and its personnel to deliver health care services to the below named minor child enrolled in the School District of Beloit. Services provided may include, but are not limited to: medical evaluation, physical exam, x-rays, lab work, immunizations, sports physicals, reproductive health care, mental health services, and alcohol and drug abuse services (collectively, "Health Care").

I request and authorize BHS and its personnel to deliver Health Care to the below named minor child as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Name: _____ Date of Birth: _____

I acknowledge that state law allows minors to consent to and obtain certain Health Care without parental consent. In those situations, I acknowledge that the above named minor child may still be able to obtain certain Health Care from BHS without my authorization and that BHS will comply with all applicable laws regarding consent requirements.

I understand that the provision of Health Care is not an exact science and I acknowledge that no guarantees have been made to me as to the results of Health Care received from BHS.

FOLLOW-UP RESPONSIBILITY
I understand that BHS may provide instructions to follow at home and that it is my responsibility to arrange follow-up care and to follow through on any instructions provided. I understand that I should contact BHS if I have questions about any necessary follow-up care or instructions.

MISSED APPOINTMENTS
I understand that missed appointments impact the ability of BHS to provide quick access to patients. I agree to notify BHS 24 to 48 hours in advance of a cancellation or for rescheduling.

RELEASE OF INFORMATION FOR BILLING PURPOSES
I agree that BHS will release to and receive from my insurers, other payers or other persons as necessary for billing and related purposes, at reasonable times and in accordance with current policies and procedures, any information which may be needed for the purpose of billing, collection or payment of claims for services provided. This information may include the minor child's identity, medical and psychological evaluations, diagnosis, prognosis and treatment for physical and/or emotional illness, developmental disabilities, treatment of alcohol or drug abuse, progress notes, and all other information contained in health care records to the extent that such records are needed for billing or collection of benefits due from any payer. I understand that I have the right, upon request, to inspect and receive a copy of all such records being disclosed.

ASSIGNMENT & FINANCIAL AGREEMENT
In consideration for the Health Care provided by BHS, I assign to BHS any insurance benefits due from any third party covering incurred expenses. I understand that BHS will attempt to obtain any approvals and authorizations required by any applicable insurance but that ultimately I am responsible for making sure any Health Care provided is covered by insurance and for paying any additional money owed BHS for the Health Care.

If my minor child is a Medicare or Medicaid beneficiary, I request that payment of authorized Medicare and Medicaid benefits be made on my minor child's behalf to BHS for any and all Health Care provided by BHS. I agree that these benefits otherwise payable shall be paid directly to BHS and that this agreement cannot be revoked without my and BHS' consent. If I receive payment directly from my minor child's insurance company, it is my responsibility to give it to BHS within 30 days of receipt.

If Health Care provided to my minor child is not covered by Medicare, Medicaid or other applicable insurance, I will be responsible to BHS for payment of the entire bill. If my minor child is a Medicare beneficiary, I understand that I will receive notice that the Health Care will not be covered. If, following this notice, I choose for my minor child to still receive the Health Care, I will be responsible for paying the entire bill. If the amount covered by Medicare, Medicaid or other insurance is not enough to cover all of the BHS charges, I may be responsible for the payment of the difference to the extent permitted by law and applicable payer policies. I agree that any credits or amounts received by BHS greater than my balance may be applied to other balances me or my family owe BHS. I agree to pay for the charges not covered by this assignment, including but not limited to co-payments, co-insurance and deductible charges, in accordance with BHS' regular rates and terms as applicable.

COLLECTION
If BHS is not paid for Health Care received by my minor child, the account or unpaid portion of the account may be referred to an attorney for collection. I agree that I will also be responsible for all reasonable attorney fees, including BHS' attorney fees and my personal attorney fees, and any other costs, fees or expenses incurred as a result of the collection process as allowed by Wisconsin law.

PATIENT'S CERTIFICATION/PAYMENT REQUEST
As applicable, Patient's Certification/Payment Request under Title XVIII and Title XIX or the Social Security Act (Medicare/Medicaid): I certify that information given by me in applying for payment under the Title XVIII and Title XIX of the Social Security Act and Wisconsin's Medicaid Assistance law is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf.

DOCUMENT ACKNOWLEDGEMENT
I have read and understand this entire Preauthorization and Consent to Treat Minors form and am competent and authorized to sign this document. I understand that I am not entitled to make any changes or alterations to this document. I will notify BHS if my minor child's insurance coverage (including eligibility for Medicare or Medicaid), home address or other contact information change.

_____ _____
Patient/Legal Guardian signature Date

Relationship to Patient: ☐ Parent ☐ Legal Guardian

THIS PREAUTHORIZATION AND CONSENT TO TREAT FORM IS EFFECTIVE INDEFINITELY UNLESS OR UNTIL YOU REVOKE THIS FORM IN WRITING TO BHS.

BELOIT HEALTH SYSTEM, INC.
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing this form, I acknowledge that I received a copy of BHS' Notice of Privacy Practices ("NPP") which:

- Explains how BHS uses and discloses health information;
- Outlines my privacy rights with regard to my protected health information;
- Details BHS' obligations to me concerning use and disclosure of protected health information; and
- Provides a contact for additional information on BHS' privacy policies.

_____ _____

Patient/Legal Guardian signature Date

Relationship to Patient: ☐ Parent ☐ Legal Guardian