DEPARTMENT OF HEALTH SERVICES

TELEPHONE: 505-869-3200
FAX: 505-869-4586

PUEBLO OF ISLETA

1 SAGEBRUSH STREET
P. O. BOX 580
ISLETA, NM 87022

Assignment of Benefits:

I, the undersigned, hereby authorize payment under my Medical/Dental/Pharmacy coverage for any Medical/Dental/Pharmacy services and supplies rendered to me to be paid directly to the Pueblo of Isleta, Health Center. In addition, I authorize Pueblo of Isleta, Health Center to release to my insurance carrier or its representative any information needed from my medical/dental/pharmacy records concerning the examination or treatment rendered to me that is necessary to process an insurance claim. _________
Patient initials

Consent to Treatment:

I, the undersigned, hereby give consent to the Pueblo of Isleta, Health Center to provide services and administer Physician/Dentist/Behavioral Health Licensed Therapist orders. I understand that the Physician/Dentist/Behavioral Health Licensed Therapist is responsible for explaining Medical/Dental/Behavioral Health Licensed Therapist diagnosis and treatment to me and that certain procedures require a separate consent. _________
Patient initials

Acknowledgement of receipt of notice of Privacy Practice:

I, the undersigned, hereby acknowledge receipt of the Pueblo of Isleta, Health Center notice of Privacy Practices. _________
Patient initials

Acknowledgement of receipt of notice of Patient Rights and Responsibilities:

I, the undersigned, hereby acknowledge receipt of the Pueblo of Isleta, Health Center notice of Patient Rights and Responsibilities. _______
Patient initials

Patient Name	Signature	Date

***If patient is under 18 and unmarried, parent/guardian must sign below.**

Parent/Guardian	Signature	Date

Addendum to Patient Registration Update form (PMAS. Facesheet)

Medical Record No.__________________