ASSURED HEALTH CLINIC

8421 W Broadway Ave, Brooklyn Park, MN, 55445

ACKNOWLEDGEMENT AND CONSENT FORM

We are required by law to ask you to sign this form each year. **This form is important to your privacy rights.

Arranging Payment

> **Assignment of benefits and responsibility for payment:** *This allows us to bill your health plan and receive payment directly, it also means that you agree to pay for services not covered by your health plan.*

- I authorize my caregiver to bill my health plan and other third-party payers, directly on my behalf, and to receive direct payment of authorize benefits. I agree that it is my responsibility to pay for any healthcare services not covered by my health plan, including but not limited to co-payments, deductibles or co-insurance.

Release of Information

> **For care, payment and operations:** *This allows us to coordinate your care with other healthcare providers and to bill for services. this also allows your health plan to process your claims and provide other services to you.*

- I authorize my caregiver to release information from my health records to my other healthcare providers for treatment, payment or healthcare operations.

- I authorize my caregiver to release information from my health records for purposes of processing and paying claims, coordinating benefits, coordinating care, quality care review studies, and other functions that support treatment, payment and healthcare operations, including those functions that my caregiver is required by my health plan or other third-party payers to perform.

- I authorize my health plan to release health information to appropriate accreditation and quality review/measurement personnel, to disease, pharmacy, or case management providers and to other third parties for purposes related to treatment, payment, or healthcare operations.

Patient Rights and Privacy Practices

- You and your family's rights and our privacy practices are posted in main areas within Assured Health. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your caregiver.

Signature and Acknowledgement

I understand that I may revoke (cancel) this consent, in writing anytime. Revoking consent does not apply information that has already been disclosed.

Print Name of Patient	**Patient Birthdate**
Print Name of Legal Representative	**Relationship to Patient**
Signature of Patient or Legal Representative	**Date**