**Fee Consent**

Thank you for choosing Mayo Family Healthcare. To reduce any confusion between you and our office, we have listed our financial policy. Please call our office with any concerns or questions regarding the policy. We look forward to taking care of all your healthcare needs.

1. It is your responsibility to know your coverage and benefits. Our office requires payment at time of service. This may include copay, co-insurance and or deductible. We will submit to your insurance as a courtesy. Please note that the submission to your insurance is not a guarantee of payment.
2. Please bring a current copy of your insurance card and photo ID. If proof of insurance is not provided, we will set up your account as a self-pay account and collect in full. Please advise our office of any changes to your insurance, address, phone number or name change.
3. To provide the best service and availability we ask that a 24-hour notice be given if you need to cancel or reschedule. A $25 no show fee will be charged if no notice is provided.
4. If your checks are returned, we will add a $35.00 inconvenience fee to your account (in addition to all other bank and collections fees).
5. I hereby authorize direct payment to Mayo Family Healthcare of any payments or other benefits to which I or the patient may be entitled from any government program, insurance company, or other entity that is or may be liable for the cost associated with the patient’s care.
6. After 3 statements the billing department will make 2 attempts to call you and collect your past due balance, if no arrangement is made your account will be transferred to a 3rd party collection company.
7. I understand that costs given by the clinic is only an estimate. Mayo Family Healthcare cannot guarantee payment from the insurance company.

I have read and understand the financial policy and agree to the terms. I understand that Mayo Family Healthcare reserves the right to change or amend any policies at any time.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**OVER 🡪**

**HIPAA and Consent for Treatment**

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective on April 14, 2003, we are required to maintain the privacy of your health information and to provide you with a written notice of our legal duties and privacy practices with respect to such protected health information.

**Permitted Disclosures**

Our practice is permitted to use and disclose your PHI for treatment, payment, and health care operation purchases. These uses include sharing your PHI with other health care providers for coordination of care, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of your appointment and account balances. We are also permitted to disclose your PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. We may also disclose your PHI to family members, relatives, or a close personal friend when the information we disclose is relevant to the individual’s involvement with your care or is required to assist in your health care (e.g., pick-up prescriptions or other documents, note follow-up care instructions, etc.) We will disclose your PHI when we refer you to other physicians or providers of health care. Finally, we reserve the right to change a privacy practice described in this notice as may be permitted or required by law and to make such change effective for all protected health information.

**Concerns**

If you believe your privacy rights have been violated, you may make a complaint by contacting the practice. You may mail your complaint or email to the following:

Address: 5826 E Franklin Road. Nampa, ID 83687

Email: jana@mayofamilyhc.com

CONSENT FOR TREATMENT: I voluntarily consent to care and treatment as the patient by Mayo Family Healthcare and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical surgical, nursing, and therapeutic car; diagnostic, laboratory, and radiological tests and procedures. Administration of pharmaceuticals or anesthesia, and other care as deemed reasonably necessary or advisable by the attending physician, practitioner, or staff member. If practice personnel suffer a needle stick or is exposed to blood or bodily fluids, I consent to the testing of any blood borne disease for the protection of practice personnel.

INJURY CAUSED BY THIRD PARTY: Please indicate the following.

 My condition was NOT caused by the wrongful act or omission of another person

 My condition WAS caused by the wrongful actions of the following person(s):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the patient or the patient’s legal authorized representative and have authority to execute this Consent and Agreement on behalf of the patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_