La Red Health Center
21444 Carmean Way
Georgetown, DE 19947
P. (302) 855-1233
F. (302) 855-1020

Authorization for Treatment and Financial Disclosure

I, _____, authorize examination, diagnosis and general treatment (including but not limited to use of x-ray and other non-invasive procedures, such as diagnostic test) to be performed by the medical staff of the health center. If necessary, I also give my permission for the allied health professionals (social services, nutritionists, nurses, health educators, counselors, etc.) to review my medical record for the purpose of evaluating my overall health needs. I realize that if a medical procedure is required, I will be given additional information.

I hereby authorize the health center to furnish information from my medical record to any health care provider, which my physician deems necessary to provide for the continuity of my medical care except as follows: (Please list any exceptions or write NONE)

_____

I also authorize this health center to furnish information from the medical record to any insurer, compensation carrier, health facility or social services agency that may be providing financial assistance for my care.

I assign and authorize payment to be made directly to this health center of all insurance benefits and agree to pay, in a timely manner, any unpaid balance that is my responsibility.

Patient/Parent/Guardian Signature: _____ Date: _____

Medicare Information

I request that payment of authorized Medicare benefits be made to the health center for the services furnished to me. I authorize any holder of medical information about me to release it to the Health Care financing Administration and its agents any information need to determine these benefits payable for related services. I hereby authorize Medicare to furnish to this health center any information regarding my Medicare claims under Title XVIII of the Social Security Act. I understand that any service not covered by Medicare will be my financial responsibility to pay the health center.

I have read the above and understand and accept these terms. If I should refuse treatment or leave the facility without written consent of the physician, I hereby release the physician and the health center of all responsibility for my action. I further authorize the health center personnel to take cultures and use precautions deemed necessary for infectious cases. I am aware of the above contents, but understand that except to the extent that action has been taken based on my authorization, I may withdraw my authorization at any time by written notification to the involved parties.

Patient/Parent/Guardian Signature _____ Date: _____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received, read and understand your *Notice of Privacy Practices.* I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the front of this form to obtain a current copy of the Notice of *Private Practices*.

I understand that may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

This notice is effective as of _____, 20_____and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* currently and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office.

Patient Name: _____ Relationship to Patient: _____

Signature:_____ Date: _____

Witness_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices acknowledgement, but was unable to do so as documented below:

Date:	Initials	Reason: