PATIENT NAME: _____ BIRTH DATE: _____

**Authorization for medical treatment** – Clinical personnel at Clay Center Family Physicians are hereby authorized to administer any medical diagnostic or therapeutic treatment as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

**Disclosure of Information** – I understand that my medical records and billing information are made and retained by this practice and are accessible to office personnel. Office personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. This practice and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the practice's charges and to any health care provider who is or may become involved with my care. Kansas law requires that this practice advise you that this information authorized for disclosure may contain drug/alcohol information; mental health information; and information regarding communicable or venereal diseases, including but not limited to hepatitis, syphilis, gonorrhea, HIV, and AIDS. By signing this agreement, you are consenting to such disclosure.

**Assignment of Insurance Benefits** – I agree that physician benefits otherwise payable to the insured are to be made payable to the physician(s)/provider(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

**Precertification Policy** – I understand that this practice will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

**Financial Responsibility** – As consideration for the services provided, I (patient or responsible party) guarantee payment for any amount due for such services provided by this practice.

I authorize confidential medical messages to be left on voice mail/answering machines at the following numbers:

Home # _____ Work # _____

Cell # _____ Other # _____ NONE _____

**Release of protected Health Information –** Information regarding appointments and billing inquiries may be released to the following:

| NAME | RELATIONSHIP | PHONE | NAME | RELATIONSHIP | PHONE |
|---|---|---|---|---|---|
| | | | | | |
| NAME | RELATIONSHIP | PHONE | NAME | RELATIONSHIP | PHONE |
| | | | | | |

**Acknowledgement of Notice of Privacy Practices** – A complete description of how your medical information will be used and disclosed by this practice is in our NOTICE OF PRIVACY PRACTICES which you have received. A copy is posted in this office.

_____ I have ***received*** a copy of Notice of Privacy Practices. _____ I have ***declined*** a copy of Notice of Privacy Practices.

**Acknowledgement of Payment Policy** – A complete description of your financial responsibility is in our Payment Policy, which you have received.

_____ I have read and understand the Payment Policy and agree to abide by its guidelines.

**Certification** – I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement that shall be valid for three (3) years from the date of my signature, unless otherwise stated. A photo copy of this document shall have the same effect as the original.

X _____ DATE _____

PRINTED NAME: _____

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THIS CERTIFICATION SHALL BE VALID FOR ALL **MINOR CHILDREN** IN THE SAME HOUSEHOLD, LISTED BELOW

NAME: _____BIRTHDATE: _____ SEX (_____M) (_____F)

NAME: _____BIRTHDATE: _____ SEX (_____M) (_____F)

NAME: _____BIRTHDATE: _____ SEX (_____M) (_____F)

* CONTINUE ON BACK IF NEEDED*