PATIENT CONSENT FORM

CONSENT FOR TREATMENT

I hereby request and give consent for Hayley Zink, APRN to provide medical treatment to me and/or my family.

ASSIGNMENT OF BENEFITS

I assign and authorize direct payment to Pratt Community Health Clinic, PLLC of all insurance payments or other third party payers.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Pratt Community Health Clinic, PLLC to release any health information that may be necessary for either medical care or for processing of insurance benefits. I request payment of authorized Medicare/Medigap/Medicaid benefits to Pratt Community Health Clinic, PLLC and authorize release of health information necessary for processing insurance benefits to Centers of Medicare and Medicaid and other insurance agents.

PAY AGREEMENT

I agree to promptly and fully pay any charges for services at Pratt Community Health Clinic, PLLC. I understand I will be responsible for any charges not paid by my insurance. I understand I am responsible to check with my insurance provider to see which services are covered. I understand that delinquent accounts are subject to collection activity, including referral to a collection agency. If no payment has been made with Pratt Community Health Clinic, PLLC after the first statement date, my account will be turned over to an outside collection agency. All patients turned to an outside collection agency are required to make either a $100 payment (this is in addition to any co-pays or co-insurance) at the time of service for all future appointments until the collection balance has been paid in full.

EXTERNAL PRESCRIPTION HISTORY

I understand Pratt Community Health Clinic, PLLC uses an electronic health record system that allows electronic prescribing of medications. Medications are sent to the pharmacy through a secure electronic prescription connection. I agree that Pratt Community Health Clinic, PLLC may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

NON-COVERED SERVICES & CO-PAY

I understand Pratt Community Health Clinic, PLLC will file my claims to insurance; however, I agree to be the sole responsible party for all charges that remain after insurance payments. Failure to provide Pratt Community Health Clinic, PLLC with current, accurate insurance information will result in all charges becoming the responsibility of the patient/responsible party. All co-pays and co-insurance fees are due prior to services being rendered. These payments do not guarantee payment in full. Statements will be mailed for charges exceeding the initial payment made. For patients with Medicare or Medicaid, there may be an applicable co-pay for services rendered. If Pratt Community Health Clinic, PLLC is not contracted with my insurance company, I will be 100% responsible for the payment at the time of service.

RETURNED CHECKS/ACH

I understand that Pratt Community Heath Clinic, PLLC charges a $30 fee for all checks and $15 fee for all ACH transactions returned as non-sufficient funds. The original payment amount, as well as the returned check/ACH fee will be added to my next statement balance. Checks/ACH's will no longer be accepted on my accounts and all future payments must be made by cash, debit/credit card, or money order.

APPOINTMENT POLICY

I understand that if I am 5 minutes late for an appointment, I may have to be rescheduled. My provider will attempt to work me back into the schedule on the same day, but this may not always be possible and the appointment may need to be moved to a different date.

PATIENT CONSENT FOR SCRIBE AND TELEHEALTH SERVICES

I understand Pratt Community Health Clinic, PLLC provides telehealth services and uses audio scribe services. I give my permission to be audio recorded during my visits. I acknowledge that my participation is voluntary and that I may revoke this consent at any time by providing Pratt Community Health Clinic, PLLC a 30-day written notice.

PATIENT CONSENT TO SHARE PERSONAL HEALTH INFORMATION

I authorize Pratt Community Health Clinic, PLLC to share my personal health information with the person noted below. I understand this authorization is voluntary. I understand that once my information is disclosed, it may be redisclosed by the recipient, and the information may not be protected by Federal privacy laws or regulations. I understand that this consent will remain in effect until I cancel it in writing.

Name	Relationship to Patient

PATIENT ACKNOWLEDGEMENT AND NOTICE OF PRIVACY PRACTICES

I acknowledge that Pratt Community Health Clinic, PLLC has provided me with a copy of its Notice of Privacy Practices, which describes how health information about me may be used and disclosed, and how I can access this information. I have been given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Pratt Community Health Clinic, PLLC reserves the right to change the terms of this notice periodically, and that I may contact Pratt Community Health Clinic, PLLC at any time to obtain the most current copy of this notice. I hereby acknowledge that I have read, fully understand, and accept all terms of the financial guidelines and polices stated above.

Signature of Patient and/or Guarantor	Date