Name: _____

Birthday: _____

NOTCH
Northern Tier Center for Health
Federally Qualified Health Center

Please circle one of the choices for the following questions; starred sections need your attention

- **Race:** Asian / Black / Native Hawaiian / White /American Indian / Pacific Islander / More than one
- **Are you Hispanic-Latino?** Y / N
- **Preferred Language:** English / French / Spanish / Other: _____
- **-Communication Mode:** Spoken / Written / Sign
- **Are you a Veteran?** Y / N
- **Is your annual income below:** $11,881 or $23,761

Please attach the following forms to this document:

- Your facility's Face Sheet
- Payer information including a copy of the insurance card(s)
- Power of Attorney, Guardianship, Advance Directive (if applicable)

Acknowledgements:

For those healthcare providers who accept assignment, I hereby authorize any insurance carrier with whom I have a policy to pay directly to that provider any benefits of any policies of insurance to those healthcare providers who have rendered services to me and who accept such assignment. I agree to pay all charges that are not paid in full by assigned insurance.

I certify that the information I have given is complete and accurate to the best of my knowledge. I understand that failure to provide accurate information may result in termination of services at NOTCH and reporting of the failure to the federal government.

I hereby authorize Northern Tier Center for Health to obtain medication history, from community pharmacies, clearing houses such as Surescripts and/or pharmacy benefit managers for the purpose of continued treatment. (If at any time you wish to revoke this consent please ask the reception staff at your health center for the Surescripts consent form.)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **The Richford Health Center, Inc. D.B.A NOTCH** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the CMS/HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of

the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Co- Insurance and deductible are based on the charge determination of the Medicare carrier.

Consent for Treatment:

I hereby give my consent to Richford Health Center, Inc. dba Northern Tier Center for Health (NOTCH) to administer medical/dental treatment, local anesthetics and to perform any diagnostic laboratory studies necessary.

Consent for Use and Disclosure of Health Information:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected heath information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. You are entitled to a copy of this consent and a copy of the Notice of Privacy Practices.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Authorization to Verbally Disclose Protected Health Information:

I hereby authorize physicians and staff of Richford Health Center, Inc. dba Northern Tier Center for Health (NOTCH) to give verbal information about my (or the patient named below if I am the legal representative) appointments, medical care, test results and billing, with the following persons:

Name	Phone Number	Relationship to Patient
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Release of information under this authorization is limited to verbal discussions. **This authorization does not permit release of any written health information to the individuals named above. This authorization does not provide the above named person(s) with any authority, either implied or direct, over any treatment or direct care decisions.**

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the health center listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I understand that I may inspect or copy the protected health information described by this authorization. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I also authorize any institution, agency or person involved in my care to release my personal health information to the above indicated health center or dental clinic. This consent for authorization will expire and be renewed on the first service date of each calendar year.

_____ _____

(Print Patient Name and Date of Birth) **(Patient Signature and Date)**

(Signature of Representative and Date if Applicable) **(Authority or Relationship of Representative)**