NORTHWEST FAMILY CLINICS

Consent For Treatment

CONSENT FOR TREATMENT: By signing this form, I consent and authorize Northwest Family Clinics to treat me. I understand that this could include education, medication management, labs, imaging, and procedures. I understand that my provider is available to explain the purpose of the treatment and procedures and that I have the right to refuse the recommended treatment.

ASSIGNMENT OF BENEFITS and BILLING AUTHORIZATION: I hereby request payments of authorized insurance benefits to be made directly to Northwest Family Clinics on my behalf for any services rendered to me at this facility. I consent Northwest Family Clinics to release my health records and other information related to my health care services for payment health care operations purposes.

RELEASE OF INFORMATION TO PAYER AND NETWORKS: I authorize Northwest Family Clinics to release requested health records and other information related to my health care service to Medicare, its agents, my insurance company, or health maintenance organization, other payers, payer network organizations, including accountable care organizations, their contractors, third-party administrators, state medical agency, or any other governmental payor as needed for payment and health operations. Any follow-up or reporting to third parties that becomes necessary due to unpaid balances on your account shall not be considered breach of confidentially.

PAYMENT AGREEMENT: I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered to myself or my dependent. If, for any reason my insurance carrier deems certain services as non-covered or does not pay for any portion of my bill, or if, I do not have active insurance coverage, I assume full responsibility for payment of those and all other charges for services rendered. All copays, coinsurance, and deductibles are due at the time of service. We accept cash, checks, credit and/or debit cards. There is a $45 service fee for return checks or credit card chargebacks. If circumstances require the use of a third-party collection agency, I understand that I will be responsible for payment of the collection cost, attorney, and/or court fees. Any fees will be applied to the collection balance. The collection agency may also report your delinquent account to the credit bureau.

PATIENT'S RIGHT TO PRIVACY: By signing this form, I acknowledge I have received a copy or have been made aware of Northwest Family Clinics' Privacy Practices. I understand I may request a copy of this privacy notice.

PRESCRIPTION REFILLS AND CONTROLLED MEDICATIONS: Northwest Family Clinics provides enough refills and renewed prescriptions at the time of your appointment. You are responsible for tracking your medication supply and scheduling an appointment before the medication runs out. You should contact your pharmacy to submit a refill request and allow at least 72 hours (3 business days) for your request at minimum.

MISSED OR LATE CANCELLED APPOINTMENTS: I acknowledge that by not cancelling my appointment at least 24-hours in advance or not showing up for my appointment prevents others from being scheduled. I understand a charge of $50 for appointments and $100 for procedures may be charged to my account for the missed or late cancelled appointment. Colonoscopies must be cancelled at least 7 days in advance or a charge of $300 may be charged for the late cancelled appointment. Further, I understand that Northwest Family Clinics reserves the right to terminate my care or place me on a same day appointment restriction for three or more missed or late cancelled appointments without giving 24-hour notice within a 12-month period.

OTHER CHARGES MAY INCUR: If Northwest Family Clinics is asked to complete additional forms or reports for you, there may be additional charges. These fees will not be billed to your insurance company and are pre-paid. Northwest Family Clinics may charge fees for items such as but not limited to disability forms, FMLA forms, copies of medical records, special reports, e-communication, or phone consults.

ELECTRONIC NOTIFICATIONS: By supplying my phone number, email address, or any other personal contact information, I authorize Northwest Family Clinics and its' third-party automated outreach and messaging system to use my contact information. To contact me with appointment reminders, lab results, account balance information, and other healthcare related functions. I consent to allowing detailed messages being left on my voicemail, or with below listed individual, if I am unavailable at the number provided by me.

AUTHORIZATION TO DISCUSS HEALTH INFORMATION: I hereby authorize medical providers and personnel of Northwest Family Clinics to discuss my protected health information with the named individual(s) below. By leaving this area blank, providers and personnel will not share my protected health information.

Relationship	**Name**	**Phone #**
_____	_____	_____
_____	_____	_____

By signing this form, I acknowledge I have read and agree to all the above. I understand this consent does not expire until I revoke it in writing. I understand that I have the right to revoke my consent at any time and that my revocation shall have no effect on any actions taken prior to my revocation.

Patient Name (PRINT): _____ DOB: _____

_____ _____

Legal Signature of Patient, Parent, or Legal Representative Date