PATIENT ACKNOWLEDGEMENT

- **Assignment of Benefits:** I hereby authorize that payment due to me in my pending insurance claim be made directly to Northwest Family Clinics. Payment is authorized upon your receipt of an itemized statement of services.

- **Authorization for Release for research or quality improvement:** I understand and agree that my insurance company may share my past, current and future health and account records with Northwest Family Clinics about services I've received from Northwest Family Clinics and other care providers unrelated to Northwest Family Clinics. These records may be used by Northwest Family Clinics as needed to manage or coordinate my care and to improve the quality of that care.

- **Electronic Notifications:** By supplying my home or mobile number, email address or any other personal contact information, I authorize Northwest Family Clinics to employ a third-party automated outreach and messaging system to use my personal information. The name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending or missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related functions. I also authorized Northwest Family Clinics to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voicemail, answering system, or with another individual, if I am unavailable at the number provided by me.

- **Notice of Privacy Practices:** I have been informed and offered a copy of Northwest Family Clinics Notice of Privacy Practices.

- **Patient Financial Policy:** I have been made aware that the Patient Financial Policy is available to me at my request.

- **Record Release:** I hereby authorize Northwest Family Clinics to release to my referring physician, and insurance company information, including diagnosis and records of treatment concerning my past/current medical history.

I have read and understand and agree with the above stated information. I understand this authorization will be in effect for 1 year from date signed.

Patients Signature: _____ Date: _____

Patients over 18 yrs of age must sign for themselves, if you are signing on behalf of the patient, please state your relationship _____