NEW HORIZON DIABETES CLINIC

AUTHORIZATIONS & ACKNOWLEDGMENTS

PRIVACY NOTICE

Patient Name ____ Date of Birth ____/______/_____

Acknowledgment of Notice of Privacy Practices

Initial Here ________I acknowledge that a copy of the Notice of Privacy Practices was provided to me.

General Consent to Treatment and Test

Initial Here ________ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Release of Information

Initial Here ________ I authorize NHDC to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here ________ I authorize payment directly to NHDC for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible. I also understand that I may qualify for financial assistance for services provided by NHDC and that I may request an application to apply for financial assistance. I further understand that the determination of whether I qualify for financial assistance is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my ability to qualify for financial assistance.

____ ______________________

Signature of patient/parent/guardian/ person authorized to sign for patient Date

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