Patient Authorization & Consent

Patient Name: _____ **Date of Birth**: _____

I am presenting myself for treatment at Kennedy Health Alliance (KHA). I voluntarily consent to the rendering of such care, including diagnostic procedures and medical treatment by the employees and medical staff of KHA, which, in their professional judgment, is necessary or beneficial. I understand that this consent applies to this and to all subsequent visits as a patient relating to the diagnosis and treatment of my medical condition(s).

I agree that my provider can check my external medication history at his/her discretion.

I hereby authorize payment directly to KHA of the benefits under the insurance coverage(s) identified by me which may be payable to me but not to exceed the regular charge for all services rendered. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for provider services or authorize such provider or KHA to submit claims to the insurer for payment.

I understand that I am financially responsible for all charges not paid under this assignment. I further understand that my provider cannot know all the terms of my insurance and that if my insurance declines payment for any reason I am responsible for payment of all declined charges. I understand and agree that in the event that I fail to make payment for service rendered to me, my identifying information will be turned over to a collection agency and/or attorney and I will be responsible for all costs associated with collecting payment including but not limited to attorney's fees, court costs, and collection agency fees.

The undersigned agrees, whether s/he signs as agent or as patient, that in consideration of the services to be rendered to the patient, s/he hereby individually obligates herself/himself to promptly pay the account of KHA in full upon presentation of any portion denied or not covered by the patient's insurance carrier. Provisional credits are subject to collections thereof by KHA.

I authorize KHA, along with any billing service and/or their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automated telephone dialing devices or other computer assisted technology, or by electronic mail, text messages or by any other form of electronic communication.

I certify that the information given by me is correct.

I certify that I have been provided with the HIPAA guidelines for confidentiality as pertain to KHA and its providers. I understand that I may receive additional copies at any time upon request. I understand that staff is available to answer any questions regarding the HIPAA guidelines.

The undersigned certifies that s/he has read and understands the foregoing and is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

_____

Patient/Parent/Guardian Signature **Date**

The patient is unable to sign because:

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