Health Center of Huron County

Insurance/Treatment/Payment/HIPAA Authorization

Patient Name _____Birth Date _____

☐ CONSENT FOR ASSIGNMENT OF BENEFITS: I consent to assign all insurance payments for the services given today to Health Center of Huron County and understand that I am responsible for all co-payments, deductibles, and other amounts not covered by my insurance.

☐IMMUNIZATIONS: I have received and read or have had read to me, the information contained in the Vaccine Information(s) (VIS), and I have had the chance to ask questions and understand the benefits/risks of the vaccines to be received today. I grant permission for the release of this record to schools, daycare centers, and others as may be necessary. I also understand that this information is being sent to a central registry at the Ohio Department of Health.
I CHOOSE NOT TO RECEIVE THE VIS FORMS AT THIS VISIT. ☐

☐HEALTH CENTER METHOD OF PAYMENT: As a client of the Health Center of Huron County, I understand that insurance is accepted. My payment for services is based on the sliding fee scale for reduced rates. The sliding fee scale is based on the household income and the household size. Proof of income includes the most recent pay stubs from each working member of the household. "Household" consists of all people living in a single dwelling. THERE IS A MINIMUM CHARGE OF $30.00 per visit and is due at the time of service. Any procedures performed during this visit are charged at the sliding fee scale. **NOTE: Income also includes child support, workers' compensation, Social Security, and unemployment.

I hereby authorize Health Center of Huron County to examine, test, treat, immunize, and prescribe medications as determined necessary by the attending physician or nurse for myself. As the Health Center is an educational facility, I realize that, at times, there may also be a student nurse present. I may also decide not to allow the student nurse practitioner, or student nurse to assist with care. I understand that all information obtained through and/or due to my visit shall be confidential.

I give my consent to Health Center of Huron County (HCHC) to use and disclose my protected health information for the purpose of treatment, payment, and operations of my health care and this clinic. I understand that I have the right to revoke this consent in writing at any time. However, such a revocation shall not affect any disclosures HCHC has already made in reliance on my prior consent. I understand that I have the right to request a restriction or limitation on the medical information HCHC uses or discloses about me for treatment, payment, or health care operation. This request must also be done in writing, and I understand that whenever possible HCHC will honor my request.

NOTICE OF PRIVACY PRACTICES: HCHC provides information about how we may use and disclose protected health information about you. The Notice contains a patient rights section describing your patient rights under law. You have a right to review this notice before signing this consent. HCHC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have had the chance to review the Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may get those changed notices by contacting HCHC by phone or in writing.

☐I authorize HCHC to bill my health insurance on record
☐I have health insurance, however the services provided are not covered and I will pay out of pocket
☐HCHC is a non-participating provider with my health insurance carrier and I will pay out of pocket
☐I do not authorize HCHC to bill my health insurance for services provided and will pay out of pocket
☐I do not have insurance and will be self-pay

Authorized Signature _____Todays Date _____