Patient Information & Authorization: Duluth Family Practice Center

This authorization is valid for one year from the date of signature

CONSENT FOR GENERAL CARE

I present myself for health care services at Duluth Family Practice Center to be provided by authorized employees of the clinic and medical staff as, in their professional judgment, be deemed necessary or beneficial. I realize that among those who attend patients are medical, nursing and other health care personnel in training who, unless requested otherwise, may be present during patient care as part of their education. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments on my condition.

When a health care worker is exposed to my blood or other potentially infectious materials through any eye, mouth or other mucous membrane, non-intact skin or parenteral contact, I consent to a test of my blood to screen for the presence of Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), or any antibody to the HIV virus, the cause of Acquired Immunodeficiency Syndrome (AIDS). I also consent to the release of reasonable necessary portions of my medical record to assist Duluth Family Practice Center in assessing potential risk related to such exposure. I authorize Duluth Family Practice Center to release the test results to the exposed health care worker and any health care professional responsible for evaluating the exposed health care worker. I understand that I may have the right to consent to release of my test results to myself and/or my primary care physician.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the Duluth Family Practice Center to release my medical records (including transfer records) and/or my business office records to other healthcare providers and anyone else the Duluth Family Practice Center believes to be involved in my care and treatment. I authorize the Duluth Family Practice Center to electronically release my medical record information to other healthcare providers involved in my care and treatment, and who share electronic medical record systems with the Duluth Family Practice Center. This includes information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases, HIV test results, developmental disabilities and genetic testing results. I may revoke this consent at any future date upon written notification to Duluth Family Practice Center; however, I understand Duluth Family Practice Center may release information in good faith from the date I sign this consent until the date I may choose to revoke it. I authorize use of my medical records and information for legitimate medical or scientific research purposes.

MEDICARE / MEDICAID PATIENTS

I certify the information I gave in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request payment of authorized benefits on my behalf for any services furnished me by Duluth Family Practice Center including physician services, and assign such benefits to Duluth Family Practice Center. I authorize Duluth Family Practice Center to release to Medicare/Medicaid and its agents any information needed to determine these benefits or related services. I understand I am responsible for the costs of non-covered services and for the deductible, co-insurance and co-payment charges allowed under federal regulations.

RECORD LOCATOR SERVICE

As authorized by Minnesota Statute 144.293 and the 2007 Wisconsin Act 108, Record Locator Service(s) allow authorized health care providers to quickly find the location of health information about you from participating providers.

OPT OUT

☐ If I select this option, I am specifically requesting that my identifying information and location of my health information from any Record Service(s) be excluded from access by any participating provider.

_____ _____

Signature of Patient or Authorized Representative Date

Reason patient did not sign: _____

DULUTH FAMILY PRACTICE CENTER NOTICE OF PRIVACY PRACTICES

I acknowledge being offered the Duluth Family Practice Center's Notice of Privacy Practices. _____initials

FINANCIAL AGREEMENT

I agree to pay Duluth Family Practice Center for all services provided me by Duluth Family Practice Center at the regular rates. This includes services which, for any reason, are not paid by insurance, government programs or other third party sources. I understand that any self-pay portion of my clinic bill is due upon notification. I further agree to pay reasonable attorney's fees and all costs of collection in the event my account is turned over to an attorney or collection agency.

I authorize payments be made directly to Duluth Family Practice Center of insurance, Medicare/Medicaid benefits or other funding sources I am entitled to as payment for services provided me. I understand professional (physician) services for radiology, lab, and pathology are charged separately from my clinic bill and that I am financially responsible to those physicians for any charges for their professional services. If assignment of insurance benefits is accepted by such physicians, I authorize insurance payments be made directly to those physicians.

I accept financial responsibility as outlined above: _____ _____

Signature of Guarantor Date