Pendleton Primary Care Clinic

Treatment Authorization Form

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Consent To Treat

By signing below I am allowing Pendleton Primary Care Clinic LLC (PPCC) to provide health care related treatment and consultation to the previously-names patient and that I may refuse treatment or services at any time. I understand PPCC does not guarantee any outcome for any services or treatment whether stated or implied.

Assignment, Release and Authorize

I, assign directly to PPCC, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the provider or clinic to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

HIPAA (Health Insurance Portability and Accountability Act)

I understand that I have the right to review a written description of how PPCC will handle my health information. The written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of PPCC and my right regarding my health information. I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of a revised Notice of Privacy Practices. I also understand that a copy of or summary of the most current version of PPCC's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

Patient Confidential Communication

The HIPPA gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following:

I give permission to PPCC to leave message regarding: Appointments____ Billing_____

Medical information, such as results, medication information, generic recommendations, or referral status or updates will be given to the patient only unless specified here:

Name: _____ Phone #: _____ Relation to Patient:_____

_____	_____	_____
Patient/Representative Name	*Signature*	*Date*