Healing Hands Resource Center

Safe Place Clinics

Integrated Health Services

Name: **DOB** **Medicaid RIN:**

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by Healing Hands Resource Center (HHRC) and its employees or designees. I authorize the behavioral and physical health care services deemed necessary or advisable by my caregivers to address my needs. (_____)
Initials

AUTHORIZATIONS FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of HHRC. I authorize HHRC to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that HHRC may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (____)
Initials

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE: I authorize payment to be made directly to HHRC for insurance benefits payable to me. I understandthat I am financially responsible to HHRC for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account isreferred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees. (_____)
Initials

PRIVACY POLICY: I acknowledge having been offered HHRC "Notice of Privacy Policies" and "Summary of Client's Rights and Responsibilities." My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the policy. My right to make a complaint and file a grievance under Illinois laws has also been explained. I understand that I may revoke in writing my consent for release of my health care information, except to the extent HHRC has already made disclosures with my prior consent (____)
Initials

_____ _____

Patient or Guardian Signature/Printed name Relationship Date

_____ _____

Witness Signature Date

Patient unable to sign. Verbal consent given. Reason: _____