Patient's Full Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Social Security No: _____-_____-_____ Date of Birth: _____ Male: _____ Female: _____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (needed if patient is under 18 years of age) Date

****

INSURANCE POLICY INFORMATION

PRIMARY INSURANCE
Insurance Company Name: _____
Policyholder's Employer: _____
Policyholder's Name: _____ Policyholder's Birth Date: _____
Policy # _____ Group #_____ Relationship to Patient: _____
Policyholder's Address: _____
Street City State Zip

SECONDARY INSURANCE
Insurance Company Name: _____
Policyholder's Employer: _____
Policyholder's Name: _____ Policyholder's Birth Date: _____
Policy # _____ Group #_____ Relationship to Patient: _____
Policyholder's Address: _____
Street City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS:
Please initial

____ I understand that **I am financially responsible** for *all* charges for professional services, whether or not paid by an insurance carrier or health plan. ($30 fee for insufficient funds)

____ I understand that **I am financially responsible** if my insurance coverage is limited by managed care (PPO, HMO, etc) contracts.

____ I authorize and request the above named insurance company to pay benefits for services rendered.

____ I authorize Mankato Acupuncture Clinic, LLC to release all medical information necessary to process my health insurance claims.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (needed if patient is under 18 years of age) Date