## AUTHORIZATION TO BILL INSURANCE AND ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize NCNC to directly bill my insurance company and I further authorize any third-party payer through which I have benefits to make payment directly to NCNC. I understand that I am financially responsible for any balance. I also authorize NCNC or insurance company to use and disclose any healthcare information for the purpose of obtaining payment for services and determining insurance benefits. Services provided by outside companies, (i.e., lab, pathology, radiology) are billed separately by those companies.

X_______________________________________________ X ________________________________________________

Patient/Guardian Signature Date

## CONSENT TO TREAT

I consent to be a client at NCNC. I understand that this clinic is affiliated with the Purdue University of Nursing, West Lafayette. I understand that advance practice nurses provide the healthcare at this clinic. I understand that if nursing students assist in providing healthcare that they are under the supervision of a professional nurse. I understand that all information about me, as an individual will be kept confidential as per HIPAA rules.

X_______________________________________________ X ________________________________________________

Patient/Guardian Signature Date

## AUTHORIZATION FOR RELEASE OF IMMUNIZATION INFORMATION

By signing below, I authorize NCNC to release to or to request from schools, day care centers, state/local health departments and health care providers all immunization information relating to the above patient. The purpose of receiving/releasing this information is to monitor that the above patient receives all his/her immunizations. This information will be utilized for follow-up services provided by schools, day care centers, state/local health departments and health care providers to the above patient, and may be release or received by oral communication, in written form, or by computer. I understand that I may revoke this authorization at any time in writing, but the request shall remain valid until revoked. A photocopy of this authorization has the same effect as an original.

X_______________________________________________ X ________________________________________________

Patient/Guardian Signature Date

## CONSENT TO TEXT OR EMAIL USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE REMINDERS

By signing below, I consent to receive text messages from the practice at my phone number or email to receive appointment reminders, and general health reminders of information. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I also acknowledge this means of communication is not considered secure for the transmission of private information.

X_______________________________________________ X ________________________________________________

Patient/Guardian Signature Date

HEALTH CLINIC
North Central Nursing Clinics

## HIPAA CONSENT FOR RELEASE OF MEDICAL INFORMATION TO SPOUSE, RELATIVES OR FRIENDS

By signing below, I authorize NCNC to disclose private medical information if I am unavailable or incapacitated for any reason to:

______________________________________________. This party is my __________________________________________.

(Name of Person) (Relationship to the patient)

This □ Includes □ Excludes HIV/AIDS information.

PH:_________________________________________

This agreement will remain in effect until I advise the disclosing entity in writing. [_] I Decline

X_____________________________________________ X ________________________________________________

Patient/Guardian Signature Date

## NOTICE OF PRIVACY PRACTICES AND COMPLAINT PROCEDURE PATIENT ACKNOWLEDGEMENT FORM

- The North Central Nursing Clinics' Notice of Privacy Practices describes how patient's medical information may be used and disclosed and outlines your rights regarding this protected information.
- The North Central Nursing Clinics' Complaint Procedure enables patients to file a complaint regarding their medical treatment, the NCNC billing practices or the general operating policies of NCNC. Patients may submit written complaints.

Your signature indicates that you have read, understand and acknowledge NCNC's Notice of Privacy Practices and Complaint Procedure.

X_______________________________________________ X ________________________________________________

Patient/Guardian Signature Date