Miracle Hills Clinic Consent Form

CONSENT & AUTHORIZATION

CONSENT TO MEDICAL & SURGICAL PROCEDURES: I authorize that I am 19 years of age or older and/or the parent or legal guardian of the patient listed below. I hereby voluntarily consent to outpatient care from Miracle Hills Clinic encompassing routine medical and surgical care and treatment as deemed necessary or advisable in the judgement of the provider(s), which may include but is not limited to: laboratory procedures, medical and/or surgical treatment and/or procedures, anesthesia, or other services rendered to the patient under the general and special instructions of the provider(s).

VALIDITY OF CONSENT: I understand that this consent form shall be valid as long as I am a patient of Miracle Hills Clinic.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Miracle Hills Clinic to release any information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

HEALTH INFORMATION EXCHANGES: Miracle Hills Clinic endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who participate in the **Nebraska Health Information Initiative (NEHII)** program and who are treating you, to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the NEHII HIE, or cancel an opt-out choice, at any time by completing the appropriate form which will be provided upon your request.

Miracle Hills Clinic endorses, supports and participates in the **Nebraska State Immunization Information System (NEIIS).** The Nebraska State Immunization Information System (NESIIS) is a secure, statewide, web-based system that connects and shares immunization information among public clinics, private provider offices, local health departments, schools, hospitals, and other health care facilities that administer immunizations and provide medical care to Nebraska residents. NESIIS maintains computerized immunization data for people of all ages in a confidential and secure manner. Information in the NEIIS system can be released only to individuals; individual's parent/legal guardian; individual's healthcare provider; a school or child care center where the individual is enrolled; health insurers if financially responsible for immunizations; healthcare organizations; Department of Health Care Policy and Financing for individuals enrolled in Medicaid. You may choose to opt-out of participation in the CIIS system or cancel an opt-out choice. This notification must be
in writing and may be presented at any time.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT: I have received, read and understand the Miracle Hills Clinic Notice of Privacy Practice in a more complete description of the uses and disclosures of my health information.

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FINANCIAL POLICIES

PROOF OF INSURANCE: I understand that it is my responsibility as the patient to provide current insurance information to Miracle Hills Clinic. In order to properly bill insurance, Miracle Hills Clinic requires that the patient discloses all insurance information including primary and secondary insurance cards, as well as, any change of insurance information within 60 days of service. Failure to provide insurance information may result in patient financial responsibility for the entire bill. If insurance information is not provided and/or we do not participate in your insurance plan, payment in full is expected from you at the time of your visit.

ASSIGNMENT OF BENEFITS: I understand that Miracle Hills Clinic will bill my insurance carrier as a courtesy to myself, the patient. It is my responsibility as the patient to determine if my insurance carrier is in network with Miracle Hills Clinic. In consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I hereby assign Miracle Hills Clinic all rights, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding Miracle Hills Clinic's regular and customary charges for the health care services rendered. I authorize payment of medical benefits by any insurance carrier to either the Clinic or myself. I understand that insurance is a contract between myself and the insurance carrier; Miracle Hills Clinic is not a party of this contract. In addition, I consent to any request for review or appeal by Miracle Hills Clinic to challenge a determination of benefits made by a third-party payer.

FINANCIAL RESPONSIBILITY: Subject to applicable law and in consideration of all health care services rendered or about to be rendered to me (or the below named patient), I agree to be financially responsible and obligated to pay Miracle Hills Clinic for the patient balances due. The parent or legal guardian of a minor patient (under 19 years of age) is responsible for payment on the minor's account. I understand that if my insurance carrier pays me directly, I am responsible for payment and agree to forward the payment to Miracle Hills Clinic immediately. **I understand that All copayments, coinsurances, and deductibles may apply. I understand that copayments are the patient's responsibility and are due at the time services are rendered.** I understand that if I (or the below-named patient) is uninsured, my account is my responsibility and the self-pay fees are due at the time services are rendered.

I understand that I have the right to withdraw my consent at any time. If I choose to do so, I must provide a written withdrawal to the clinic. The written withdrawal of consent will only apply after it is received, and not to any information for which I previously provided consent. I also understand that by refusing to sign this consent or revoking this consent, Miracle Hills Clinic may refuse to treat me and/or the below-named patient.

My signature below indicates that I understand and accept the terms of this form.

Signature of Patient or Patient Representative _____

Print Name _____ Date _____ Time _____

If not the patient: Relationship to Patient _____

Witness _____ Date _____ Time _____

miracle hills clinic
health & wellness