NORTHEAST MISSOURI HEALTH COUNCIL
Partners for a lifetime of health

HIPAA

PATIENT NAME_____**DOB**_____/_____/____
(Please Print)

NOTICE OF HIPAA PRIVACY PRACTICES ACKNOWLEDGEMENT:

I understand that, under HIPAA laws, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for: **treatment, payment, and healthcare operations.** I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the Northeast Missouri Health Council, Inc. (NMHC, Inc.) has the right to change its Notice of Privacy Practices from time to time and that I may contact NMHC at any time to receive a current copy.

Patient/Guardian Signature_____**Date**_____/_____/_____

INSURANCE/TX AUTH

PATIENT NAME_____**DOB**_____/_____/____
(Please Print)

ASSIGNMENT OF INSURANCE BENEFITS & TX AUTH:

I, the undersigned, authorize my insurance benefits to be paid directly to the provider of the Northeast Missouri Health Council, Inc. (NMHC, Inc.), for services rendered. I understand that I am ultimately financially responsible for any balance due not paid by insurance. I hereby authorize NMHC, Inc., to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

I, the undersigned, consent to Northeast Missouri Health Council providers and staff to perform medical/dental examinations, testing and treatment as directed by my provider. I understand that I have the right to discuss with my provider the purpose, potential risks, and benefits of any ordered tests or treatment options. I understand that if invasive or interventional tests or procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures. I understand that the consent will remain fully effective until it is revoked in writing.

Patient/Authorized Person's Signature_____**Date**_____/_____/_____

CONSENT TO TREAT/ACCOMPANY MINOR

(For patients under the age of 18 years)

DATE: _____/_____/_____

CHILD'S NAME:_____ DOB _____/_____/_____

This document is my consent as parent/guardian of the above-named child for any treatment or procedure deemed necessary by the professional staff of Northeast Missouri Health Council *(to include NE Family Health, OB/Gyn Specialty Group, NE Pediatrics, NE Dental, Kahoka Dental, Edina Family Health, NE Family Health in Milan, Macon Family Health, and Macon Dental.)*

Additionally, I authorize the following individual(s) to bring the above-named child to these clinics, besides myself: *(please print names)*

_____/_____
(relationship)

_____/_____
(relationship)

_____/_____
(relationship)

Patient/Guardian Signature_____Date_____/_____/_____