NORTHERN LIGHTS

Jacob Sauve, PA-C
Colin Rabach, PA-C

Consent for Treatment and Payment Agreement

_____
Patient Name

NOTICE OF NON-DISCRIMINATION

Northern Lights Family Medicine complies with Federal civil rights laws, and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex, including sexual orientation and gender identity, or any other category protected by law.

CONSENT TO MEDICAL CARE AND TREATMENT

I consent to all treatment ordered by my physician and other healthcare providers at Northern Lights, including all medical and surgical care, examinations and tests and procedures. I understand that there are no guarantees concerning the results of my care, and no promises have been made to me regarding the results of my treatment. I also understand that if I do not follow my Physician's recommendations that the Physician and Northern Lights are not responsible for any health conditions, injuries or damages that are the result of my non-compliance. I understand that if an employee or any individual associated with Northern Lights is exposed to my blood or bodily fluids, I will be tested for the hepatitis viruses and HIV (AIDS virus), and that my consent to this testing is not required by law. I also understand that I will receive education related to this testing and that I will not be charged for this testing and education related to the exposure.

CONSENT TO USE OF INFORMATION

Electronic Health Records (EHR). I understand that Northern Lights may collaborate with other healthcare providers to coordinate, manage and provide healthcare to me. I consent to Northern Lights sharing my health information and records electronically for the purposes of treatment, payment or healthcare operations, including improving the overall quality of healthcare services provided to me and avoiding unnecessary or duplicate testing. I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information and mental health and substance abuse treatment. The EHR will be accessible by Northern Lights credentialed physician/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA). Northern Lights has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of patient medical information as required by HIPAA.

Use and Disclosure of Information. I also agree that Northern Lights may use and disclose my health information for a range of purposes permitted by law, including treatment; eligibility verification and/or payment to private and public payors or their agents, including insurance companies, and managed care organizations; my employer (if I am injured at work); state and federal government programs; Worker's Compensation programs; obtaining pre-admission or continued length of stay certification; quality of care assessment and improvement activities; evaluating the performance and qualifications of physicians and healthcare workers; conducting medical and nursing training and education programs; conducting or arranging for medical review; audit services; ensuring compliance with legal, regulatory, and accreditation requirements; and, public health oversight services.

Request for Information from Others. I consent to Northern Lights' request of my health information from other providers of medical care to me, receipt and release of my health information, whether written, verbal or electronic, for the uses described above, as well as Northern Lights' participation in any health information exchange described in the Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT'S RIGHTS

I acknowledge that I have received or been offered a copy of Northern Lights' Notice of Privacy Practices (NPP) and Patient's Rights. These two documents provide information on how Northern Lights may use or disclose protected health information (PHI) for purposes of treatment, payment, or health care operations; and, your rights as a patient. I have had the opportunity to ask any questions about these documents. **PLEASE INITIAL** _____.

ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to Northern Lights for services provided to me. I understand that benefits may be payable to me directly if I do not provide authorization.

FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under healthcare plans, Medicare, Medicaid or other insurances or payors (e.g. services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary, but are later determined non-compensable by the payor. If pre-authorization is required by my health insurer, I understand that it is my responsibility to obtain it before services are provided. I give my consent for Northern Lights, its providers and agents, including debt collectors, to place calls to my designated cellular or residential phones using any type or artificial or pre-recorded voice or auto-dialer technologies to collect payment for services rendered. I understand a processing fee will be charged for any returned checks, and agree to pay any such fees. I also agree to be responsible for all expenses, including attorney's fees, in the collection of any monies I owe for treatment and services provided.

PERSONAL VALUABLES

I agree that Northern Lights is not responsible for any lost, stolen or damage to personal items while I am at Northern Lights, and understand that I should leave any valuables at home, or with a family member.

COMMUNICATION

I understand that my health information is accessible to me via the AthenaHealth patient portal. I hereby authorize Northern Lights to send communications about the patient portal to the e-mail address provided below. Please remember that if you share this e-mail account with a family member or friend, anyone that has access to this email account will be able to gain access to your medical records. Please choose an e-mail address with which you feel comfortable using for this purpose. I have also provided the Physician's Office with contact information, including cell or residential phone numbers. I consent to receiving telephone calls and/or text messages from Northern Lights, using my contact information for communication purposes. I understand that my consent to receiving information in this way is not a condition of my treatment.

I have read this form, and understand it. Any questions I had have been answered.

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____

Patient E-Mail: _____ Primary Telephone: _____ Call ☐ Text ☐

_____ _____

Signature of Patient or Legal Representative Date and Time of Signature

Northern Lights may release my Protected Health Information to the following individual(s):

Printed Name(s): _____