Patient Name:_____DOB:_____MRN # _____

Consent to Treat- I authorize and consent Alliance Health to the treatment deemed medically necessary by the physician/ physician's assistant for myself or my child, which may include assessment of health status/history, first aid, necessary minor procedures, physical examination, health education, referral follow-up.

Assignment of Benefits-I authorize payment of benefits to Alliance Health for services rendered to me (or my child). I understand that, to the extent permitted by law, I am responsible for **any** costs not covered under my insurance plan.

Release of Information for Payment-I authorize the electronic release of any medical or financial information, including any information related to AIDS, AIDS Related Complex (ARC) or HIV and any information regarding substance abuse treatment protected by 42 Code of Federal Regulation (CFR), part
2, and any mental health treatment, to any third party responsible for paying all or part of my (or my child's) medical bill. I understand that this authorization to release information may be revoked at any time and is only for the purpose of obtaining payment.

No Guarantee of Results of Care and Center's Termination Rights-I agree no one has promised or guaranteed any results of my or my child's medical care. I agree that nothing in this form prevents the Medical Center and its staff from terminating my or my child's care if I am given reasonable notice and a chance to obtain medical services elsewhere.

Acknowledgement of receipt of Privacy Practice

I ACKNOWLEDGE:
A copy of the Alliance Health Professionals Notice of Privacy Practices was made available to me at the place where I went for health care services. The notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy of the Notice of Privacy Practices was made available for me to keep.

Reason Acknowledgement **was not obtained** (describe reason, such as an emergency treatment situation or substantial barrier to communication):
_____
If an acknowledgement is not obtained, document below the good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was NOT obtained: _____

Patient Name (Printed): _____
Signature of Patient or Representative Name:

Print Patient Name /Date of Birth	**Patient/Parent/Guardian Signature**	**Date/Time**
Witness Signature	Date/Time	

Privacy/Communication of Protected Health Information (HIPAA)

Your privacy is important to us. Please indicate with whom we may leave messages regarding prescription refills or we can release any other patient protected health information to. This includes leaving messages or picking up any information.
Leave messages on my answering machine or with a person who answers the phone**. □ Yes □ No** **If No, please contact me at:**
I understand that my test results and protected health information are private and will not be released or given to anyone other than myself unless I authorize it. I request that the following person(s) be given my test results or protected health information if I am unavailable.

Name:	Relationship:	Telephone:
Name:	Relationship:	Telephone: