Entira FAMILY CLINICS
Where generations thrive

PATIENT AUTHORIZATION FORM

Patient Name: _____ **Date of Birth**_____
(First, Middle Initial, and Last name)

Patient Address: _____
Complete street address Apt. City State Zip code

Patient Phone #'s: **Home** ( )_____ **Cell** ( )_____ **Work** ( )_____

Email Address:_____

I HEREBY AUTHORIZE SERVICES RENDERED TO ME BY ENTIRA FAMILY CLINICS AND AGREE TO PAY FOR SUCH SERVICES INCLUDING THOSE SERVICES CONSIDERED NON-COVERED OR DENIED BY MY INSURANCE COMPANY.

ASSIGNMENT OF BENEFITS -- I hereby authorize payment of the amount due to me in my pending insurance claim be made directly to Entira Family Clinics. Payment is authorized upon your receipt of an itemized statement of services.

PRESCRIPTION HISTORY RELEASE – I hereby authorize Entira Family Clinics to view my prescription history when providing evaluation or treatment services to me.

RECORDS RELEASE – I hereby authorize the exchange / release of or access to of any information, via paper or electronic review by Entira Family Clinics with any providers, hospitals and / or specialist(s) to whom I may receive care from or be referred for care to coordinate my care, and to get complete and up-to-date information to each of the providers who treat me or to my insurance company to determine benefits and secure payment for services provided to me. I also authorize my other health care providers to release my information to Entira Family Clinics for these purposes.

HEALTH DATA EXCHANGE (initial YES or NO)

_____ Yes, I authorize and consent to the release of or access to my health information, either in paper or electronic form, by Entira Family Clinics, my other health care providers, my insurer, health plan or claims administrator for care coordination and quality improvement purposes. This includes sharing my health information from treatment I have received at health care providers not related to Entira Family Clinics. My insurer, health plan or claims administrator may also share the above information with a care system or accountable care organization in which Entira Family Clinics participates. If I do not want my health information shared for these purposes, I may opt out by initialing the statement below.

_____ No, I do not authorize my insurer, health plan, or claims administrator and provider to share my health information as described above.

Minnesota law requires us to inform you that your medical records, no matter when created may be released for the purpose of medical or scientific research unless a written objection is received.

MEDICARE PATIENT SIGNATURE AUTHORIZATION – I authorize any holder of medical or other information about me to release to the Center for Medicare/Medicaid Services, or its intermediaries or carriers, or billing agent of this physician or supplier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request that payment under Medicare be made either to me or Entira Family Clinics on any bills for services furnished me by that physician/clinic.

NOTICE OF PRIVACY PRACTICES – I acknowledge that I was given/offered the Notice of Privacy Practices today, OR at a previous visit.

CREDIT POLICY – I acknowledge that I was given/offered the Credit Policy today, OR at a previous visit.

RESPONSIBLE PARTY/FAMILY BILLING – Entira Family Clinics processes statements through "family billing". Charges for immediate family members being seen within our organization are printed on a single billing statement and mailed to the Primary Responsible Party. Billing statements may include protected health information.

☐ No, I do not authorize family billing. Please send my billing statements directly to me.

This Authorization will continue unless I cancel by giving written notice to: Entira Family Clinics at (insert address) or it expires as required by law.

Authorized Signature:_____ **Primary Dr:**_____ **Date:**_____
Patient or Legal Guardian