# INITIATION OF SERVICES

Client Name: _____

Name of Clinic: _____

Clinic Address: _____

**PART I: CONSENT TO ENTERING INTO A CLIENT-PROVIDER RELATIONSHIP** I authorize CAN Community Health and their representatives to render routine healthcare. I understand routine healthcare is confidential and voluntary and may involve medical / dental office visits including obtaining medical history and external prescription history, examination, administration of medication, laboratory tests and/or minor procedures. I authorize the use of my photograph, either by upload from government issued ID or on-site photo, to be used as visual recognition for healthcare visits and safety precautions. I may discontinue the relationship at any time.

**PART II: DISCLOSURE OF INFORMATION CONSENT** (treatment, payment or healthcare operations purposes only)
I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and healthcare operations. Substance Use Disorder medical information will not be disclosed without additional authorization in accordance with 42 CFR part 2.

**PART III: MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST (Only applies to Medicare Clients)**
As Client/Representative signed below, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above-named agency and authorize it to submit a claim to Medicare for payment.

**PART IV: ASSIGNMENT OF BENEFITS (Only applies to Third Party Payers)**
As Client /Representative signed below, I assign to the above-named agency all benefits provided under any healthcare plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

**PART V: MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____
Client/Representative E-Signature Self or Representative's Relationship to Client Date

_____
Client/Representative Name - Print

_____ _____
Witness Date

**PART VI: WITHDRAWAL OF CONSENT**

I,_____WITHDRAW THIS CONSENT, effective_____.
Client/Representative Signature Date

_____ _____
Witness Date

Name_____
ID# _____
Date of Birth_____/_____/_____