CAN COMMUNITY HEALTH

INITIATION OF SERVICES

Part I: PATIENT-PROVIDER RELATIONSHIP CONSENT

Patient Name: _____

Name of Agency: _____

Agency Address: _____

I consent to entering a patient-provider relationship. I authorize CAN Community Health, Inc. and their representatives to render routine healthcare. I understand routine healthcare is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, external prescription history, laboratory tests, STI tests, research, and/or minor procedures. I may discontinue the relationship at any time.

Part II: DISCLOSURE OF INFORMATION CONSENT *(treatment, payment, or healthcare operation purposes only)* I consent to the use and disclosure of my medical information or data which may include, without limitation, photographic images; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/ psychological, and case management; for treatment, payment, research, quality, 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 Patients)

As Patient/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 Patient/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

_____ _____ _____

Patient/Representative Signature | Relationship to Patient | Date of Birth

_____

Patient/Representative Printed Name

_____ _____

Witness | Date

Part VI: WITHDRAWAL OF CONSENT

I, _____ withdraw this consent, effective _____

Patient/Representative Signature | Date

_____ _____

Witness | Date

This Section is for Office Use ONLY

Patient Name: _____

Pt DOB: _____

Pt ID#: _____