Seneca County General Health District

71 S Washington St. Suite 1102 Tiffin, OH 44883 Phone: 419-447-3691

APPOINTMENT DATE: _____

Patient: Last Name_____ First _____ MI _____

Birth Date _____ / _____ / _____ Phone Number_____

Member _____DOB_____SSN#_____

Employer_____Ins. Carrier _____

ID#: _____ Group #: _____

Relationship to Patient: _____Bill Employer _____

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) to let you know your rights to privacy with respect to your health care information.

I give my consent to the Seneca County General Health District (SCGHD) to use and disclose my protected health information for the purposes of treatment, payment, and operations of my health care and this clinic.

Consent for release of information for payment and operations: I authorize SCGHD to give information to the identified insurance carrier(s) for any and all payment activities.

Consent related to privacy notice: I have been offered the chance to review/receive the Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may get these changed notices by contacting the SCGHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and/or given out and that this consent remains valid unless I provide written revocation.

A copy of the Privacy Notice is on display in the waiting room. A copy can be given if requested.

Initials _____ **Date** _____

Consent for assignment of benefits: I consent to make all payments for the services given today to the Seneca County General Health District. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be stated to be my responsibility by the insurance carrier, as required by any contract with my insurance carrier and state regulation. I also understand that my contract with my insurance carrier may or may not cover some services. It is my responsibility to get information from my health plan about services that are covered. If I get care outside of my plan, I am aware that I may be responsible for all charges that may be due. Failure to pay charges incurred from services received will be turned over to the collection agency.

Signature _____ Date _____

OR:

☐ I ***do not*** give permission for my insurance carrier to be billed for services. I will ***self-pay*** for all the services and fees.

Signature _____ Date _____

OR:

☐ I ***do not*** have insurance coverage for myself**.** **Initials** _____

☐ I ***do not*** have insurance coverage for my child**.** **Initials** _____