Camai
Community Health Center

CONSENT FOR TREATMENT AND BILLING PRACTICES

Printed Patient Name: _____ Patient Date of Birth: _____

Informed Consent for Treatment
I consent (agree) to health care including routine diagnostic procedures, medical treatment and other health services provided by Camai Community Health Center and its authorized personnel and agents.
I understand that:

- The practice of medicine is not an exact science and that diagnosis and treatment involve risks of injury and sometimes death. I acknowledge there is no guarantee about the results of the examinations, treatment or health services provided by Camai.
- Except in emergency or extra ordinary circumstances, no substantial procedures are performed upon a patient unless, and until, he/she has had an opportunity to discuss them with a physician or other health professional to the patient's satisfaction.
- Each patient has the right to consent or refuse to any proposed procedure or treatment plan.
- No patient will be involved in any research or experimental procedure without his/her full knowledge and consent.

_____ Patient/Guardian Initials

Notice of Privacy Practices
I acknowledge and agree that I have reviewed a copy of Camai's Notice of Privacy Practices made available to me. I acknowledge that I may request a copy of the notice at any time.

_____ Patient/Guardian Initials

Statement for Release of Information for Audit Purposes
The process of checking business records and policies is called an audit. Auditors are officials that check patient financial applications to make sure Camai is following grant rules. Auditors will only use your information to ensure that Camai is processing applications and payments correctly.

- I consent to the release of any of my financial records that may be considered necessary for review by any auditor for any assistance program that I am eligible for, or participating in.
- Audited programs may include but are not limited to sliding fee scale and grant-assisted programs.
- Financial records that may be deemed necessary for review include but are not limited to: sliding fee scale application and supporting documents, patient information, insurance information, and any other types of information contained within my electronic medical records.

_____ Patient/Guardian Initials

Please complete both sides of this form

Release, Assignment, and Statement of Responsibility
I authorize (give permission for) the release of any information necessary to process my insurance claims and assign and request payment directly to Camai Community Health Center. I understand that I may revoke (withdraw) this consent at any time in writing to this office.

I understand that:

- I am responsible for payment for all services and products provided to me, or any patient for which I am the guarantor of payment.
- I agree, whether I sign as legal guardian, guarantor, or patient to pay that account in accordance with the regular rates and terms of Camai.
- If the account is referred to an attorney or collection agency for collection, I will pay actual attorney's fees and the collection expense. If your account is 30 days past due, you may be charged interest at the legal rate.

_____ Patient/Guardian Initials

Patient Notice of Billing Practice and Office Policy
Payment for services provided by Camai is due at the time of service. We accept: cash, Visa, MasterCard, debit cards and personal checks. Payment plan options are reviewed individually.

Health Insurance: If you have health insurance, we will send the bill to your insurance company for you.

- If you are not sure if your provider is in-network or preferred with your insurance plan, please ask us before your appointment.
- We expect you to pay at the time of service for any estimated patient responsibility portion, including co-pays, deductibles, coinsurance, and/or charges for non-covered services.
- We allow a 90-day grace period for your insurance to respond to our claims. If the insurance company does not respond to our claims within 90 days, you will be responsible for paying the full balance.

Sliding Fee Discount Program: Camai is a non-profit community health center. We have a sliding fee discount for patients whose household income is below 200% of Alaska's Federal Poverty Level. This discount is available to qualified uninsured and under-insured patients.

- The Sliding Fee Discount can be used for co-pays, deductibles and co-insurance.
- If your income or household size changes, you must update your sliding fee application.
- You must update your application annually to qualify for the sliding fee discount.

_____ Patient/Guardian Initials

I have read the statements above. I understand my rights as a patient and financial responsibility to Camai Community Health Center. If I have additional questions, I will speak to a staff member before my appointment.

Patient Signature: _____ Date:_____

Printed Parent/Guardian Name: _____

Parent/Guardian Signature: _____
(if patient is under the age of 18 a parent/guardian signature is required)

Please complete both sides of this form