AMBUCARE CLINIC

NEW PATIENT CONSENT FORM

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I, _____, understand that as part of my helathcare, Ambucare Clinic orginates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that htis information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed and were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures.
I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information fro directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Ambucare Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, Ambucare Clinic may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Ambucare Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Ambucare Clinic change their notice, the will send a copy of any revised notice to the address I've provided in my chart.

I allow the following family members or medical providers to have access to my personal medical information:

_____

_____

I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Further, I permit a copy of this authoriztion to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

I fully understand and accept the terms of this consent.

_____
Patient's Signature

_____
Parent's Signature if patient under 18 years old.

_____
Date

_____
Date

Office use only:
( ) Consent received by _____

( ) Consent refused by patient, and treatment refused as permitted

( ) Consent added to the patient's medical record on_____