FRASER
Special needs ★ Bright futures®

HEALTHCARE CONSENT TO TREAT / ASSIGNMENT OF BENEFITS

Client Name (Please Print) _____ Client Birthdate _____

Legal Guardian(s) Name (Please Print) _____

Please ask questions if you do not understand any of the following sections.

AUTHORIZATIONS

Authorization for Treatment

I consent to healthcare provided by Fraser for the client named above, which may include routine diagnostic procedures and other treatment that your clinician or other Fraser clinical staff consider necessary. I may be offered medical services via telehealth systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location, and I consent to such services. I am aware that healthcare is not an exact science, and I acknowledge that no guarantees have been made to me concerning examinations or treatments from Fraser.

I understand that:

– No substantial procedures are performed on a client until the client or responsible party has had an opportunity to fully discuss them with the clinician or other health professional. Emergency situations may be an exception. Each client or responsible party has the right to consent, or refuse consent, to any proposed procedure or treatment.

Authorization to Release Health Information

I understand that these records are protected under Minnesota state laws and HIPAA regulations. They cannot be disclosed without my written authorization unless otherwise provided by law. I authorize Fraser to release health information as necessary to:

- All payers for processing health care claims;
- The person(s) designated as my Billing Addressee/Guarantor for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organization, regulatory agencies, public health reporting agencies, or other persons or entities for health care operations;
- My other health care providers for treatment or payment purposes; and
- Fraser entities for the purpose of providing information regarding the services of Fraser that may be of interest to me.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that receives the information.

I understand that this will be in effect for a period of one (1) year following the date of signature. I may revoke or amend this document only by written notice to Fraser Health Information Management.

STATEMENT OF FINANCIAL RESPONSIBILITY

Authorization for Payment

I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my health care plan(s), other than billing terms and restrictions under a government program. I authorize Fraser to apply any credit balance on my account to any amounts that I may owe to one or more Fraser entities. I agree that Fraser may obtain financial information to determine eligibility for financial assistance and/or payment options. Information on financial assistance is available by calling 612-767-7222.

I authorize my insurance company(ies) to pay directly to Fraser for my treatment. I agree, and understand:

- To provide Fraser with complete and accurate information about my healthcare insurance coverage.
- That I am responsible for knowing the benefits covered under my private insurance plan.
- That if Fraser becomes aware of other applicable health insurance, Fraser will process claims accordingly.
- That co-payments and deductibles must be paid at time of service.

FRASER
Special needs ★ Bright futures®

HEALTHCARE CONSENT TO TREAT / ASSIGNMENT OF BENEFITS

Client Name (Please Print) | Client Birthdate

Legal Guardian(s) Name (Please Print)

If I am a Medicare beneficiary, I request payment of authorized Medicare benefits to me or Fraser on my behalf for any services furnished. If my health care plan(s) will not allow direct payment to Fraser or if Fraser chooses not to accept assignment of medical benefits, I agree to pay Fraser all health care payments I receive for services.

I understand that I need to notify Fraser if there are changes in my healthcare insurance, or legal changes that affect my/my child's welfare. Further, I understand that Fraser may need to verify legal guardianship of the client through documentation.

I consent for Fraser to release any information from the above-named client's health records to Medical Assistance, other governmental payers, private health insurance companies or plans, or organizations acting on my behalf, as may be necessary to determine benefits and process claims.

Clinical Trainees

I acknowledge and consent that I/my child may be treated by a Fraser clinical trainee who is pursuing licensure or credentialing. Services in this case will be provided under the clinical supervision of a designated licensed supervisor. I understand that services are billed at the same rate under the licensed provider/supervisor.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I acknowledge that Fraser has made a copy of Fraser's Notice of Privacy Practices ("Notice") available to me:

- The Notice explains in more detail how Fraser may use and share my/my child's health information for other than treatment, payment, and heath care operations.
- Fraser will also use and share my health information as required/permitted by law.
- I have been given the opportunity to ask any questions I have regarding this notice.

USE OF HEALTH RECORDS IN RESEARCH

Research leads to new and better ways to diagnose and treat health conditions. Advances depend upon research using healthcare records. If I allow the use of my/my child's information for research, it must be handled as directed by state and federal laws. For example, my/my child's identity would be protected in published research results. If I do not allow my de-identified information released for research purposes, it will not affect my ability to participate in services at Fraser. If I choose to opt out, I can advise a Fraser staff member at check-in, or via Health Information management that I do not want my/my child's de-identified data to be included in research.

By signing, I acknowledge that I give my consent for Fraser to provide treatment. I agree that I understand and accept the terms on this form. I understand that I have the right to revoke the authorizations on this form at any time by notifying Fraser Health Information Management in writing.

Signature of client | Date

Signature of client's representative | Date

PRINT name of client's representative (if applicable) | Relationship