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.

Consent 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 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. I have received a copy of the Outpatient Client/Family Handbook, which has specific policies and procedures that relate to me/my child's treatment.

My signature on this document acknowledges that I give my consent for Fraser to provide treatment.

Release of 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 also understand my confidential health information could be shared with Fraser staff involved in my care for the purpose of Fraser's healthcare operations.

Fraser may also disclose confidential information to family members or persons involved in the client's care or those who process payment for services (for example, your health plan).

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.

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 required accrediting and quality assurance entities, or organizations acting on my behalf, as may be necessary to determine benefits and process claims.

Acknowledgement of Receipt of HIPAA Privacy Practice

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.

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Use of Health Records in Research

Research leads to new and better ways to diagnose and treat health conditions. Medical advances depend upon research using healthcare records. If I allow the use of my information for research, it must be handled as directed by state and federal laws. For example, my 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.

I agree to let my health records be used for research as described in the Privacy Notice. ☐ Yes ☐ No

UBH and Medica Clients

I acknowledge and consent that I may be treated by a Fraser provider who is not credentialed by UBH/Medica. Services will be provided under the clinical supervision of a UBH/Medica-credentialed Supervising Provider, within the preferred practice guidelines of UBH/Medica. I understand that the UBH/Medica payment will be the same as if the client was treated by a credentialed provider.

Assignment for Direct Payment / Guarantee of Account

I authorize my insurance company to pay Fraser directly for my treatment. I agree to provide Fraser with complete and accurate information about my healthcare insurance coverage. I understand that if Fraser becomes aware of other applicable health insurance, Fraser will process claims accordingly. I acknowledge that co-payment is due on the date I receive the service. I understand that I am financially responsible for all charges that are not covered by my private insurance policy.

I also understand that I am responsible for knowing the benefits covered under my private insurance plan.

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.

Signature of client _____ Date _____

Signature of client's representative _____ Date _____

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