

Notice of Privacy Practices
United Community Health Center
630 Ontario Street, Storm Lake, IA

1. Consent for treatment
 - a. I, the undersigned, hereby voluntarily authorize the professionals at United Community Health Center to administer medical care. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the clinic.
2. Authorization to release information
 - a. I authorize United Community Health Center to release such information from my medical record as may be necessary for the completion of claims submitted to my insurance company/companies or agency. I UNDERSTAND THAT DISCLOSURE MAY INCLUDE DIAGNOSES AND OPERATIONS OR PROCEDURES PERFORMED AND THAT, AT THE REQUEST OF MY INSURANCE COMPANY, COMPANIES OR AGENCIES, MY COMPLETE MEDICAL RECORD MAY BE SUBJECT TO REVIEW. IN ADDITION, I UNDERSTAND THAT COPIES OF MY MEDICAL RECORD MAY BE OBTAINED BY MY INSURANCE COMPANY, COMPANIES OR AGENCY.
3. Assignment of benefits
 - a. In consideration of the services received or to be received at United Community Health Center, I assign all insurance benefits due me. I further warrant that the clinic shall be entitled to full amount of its charges. Any credit balance may be applied to other existing accounts. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance. This assignment shall be irrevocable.
4. Payment Agreement
 - a. I hereby certify that the provided information is true and that I have reported all sources of income received to support my family. I agree to promptly and fully pay for any charges at or supplied by United Community Health Center according to the established fees.

I hereby acknowledge I have received or been offered and denied a copy of the "Notice of Privacy Practices" document

Patient or Authorized Representative Signature: _____
Relationship: _____ Date: _____

I hereby acknowledge that I have read and agree to comply with the items listed above

Patient or Authorized Representative Signature: _____
Relationship: _____ Date: _____

Patient Name _____ DOB _____ MR# _____