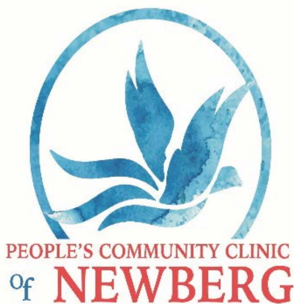


Assignment of Benefit and Release of Information for Insurance Billing

Name of Patient: ____

DOB: ____

I, the undersigned, consent to the use and disclosure of my Protected Health Information (PHI) for treatment and payment for treatment. I authorize *People's Community Clinic of Newberg, LLC, and its affiliates, its employees and agents* to release all information necessary to secure payment of benefits to my insurance company, to bill my insurance, and to assign directly to *People's Community Clinic of Newberg, LLC* all medical benefit, if any, otherwise payable to me for services and supplies rendered. I understand that *People's Community Clinic of Newberg, LLC* will share patient PHI according to the federal and state law for treatment and payment, as well as in accordance with its Notice of Privacy Practices. I authorize the use of this signature on all insurance submissions**. I acknowledge and understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company. I acknowledge and understand that all charges remaining after insurance reimbursement will be billed to my account. ________ (initial here).**

Primary Insurance Company: ____

Patient Member ID #: ____

Guarantor's Name: ____

Date of Birth: _______/______/_______ Relationship to Patient: ______________________________

Patient/Guarantor's Current Address: ____

Secondary Insurance Company (if applicable): ____

Patient Member ID#: ____

Guarantor's Name: ____

Date of Birth: ________/______/_______ Relationship to Patient: ______________________________

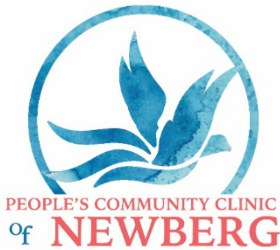
You may revoke this authorization by written notice at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to People's Community Clinic of Newberg, 1014 N Springbrook Rd, Ste B, Newberg, OR 97132 and state that you are revoking this authorization. You do not need to sign this authorization. However, refusal to sign the authorization may adversely affect your ability to receive reimbursement for services.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. I have read this authorization and I understand it. Unless revoked, this authorization will expire in one year or until **(please specify)** _________________. **If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.**

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g. power of attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_______________________________________ _________/______/________ __________________

Signature of Patient or Legal Representative/Guardian | Date | Your Telephone #



People's Community Clinic of Newberg
1014 N Springbrook Rd, Ste B.
Newberg, OR 97132
Phone: (503) 449-8988
Fax: (503) 894-9194

PEOPLE'S COMMUNITY CLINC OF NEWBERG

Authorization to Obtain Medication History

Patient Name: ______________________________

Patient Date of Birth: ______________________________

Social Security Number
(if applicable): ______________________________

Patient Address: ______________________________
____
____
____

By signing below, I hereby authorize People's Community Clinic of Newberg and its affiliates, its employees and agents to obtain the Medication History related to the patient above, from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. People's Community Clinic of Newberg and its affiliates, its employees and agents may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization.

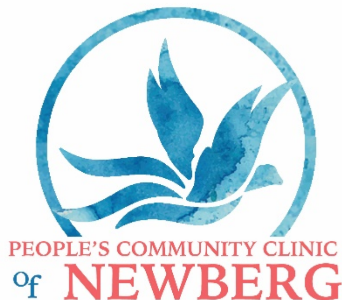
_______/_______/________
Date of Authorization

____
Printed Name of **Patient** or **Legal Representative/Guardian**

____
Relationship to Patient **(If Patient, please indicate "Self")**

____
Signature of **Patient** or **Legal Representative/Guardian**

Updated 10/17/19



HIPAA Privacy and Release of Information Authorization

Patient Name: ____

Patient DOB:____

I,_______________________________________hereby authorize People's Community Clinic of Newberg, LLC, and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.
I understand that I have a right to revoke this authorization by providing written notice to People's Community Clinic of Newberg. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
I have been advised of this practice's **1) Privacy Practices Policy, 2) Release of Billing Information Policy, 3) Assignment of Benefits Policy and/or 4) Assignment of Medicare Benefits Policy, 5) Financial Policy, and 6) Grant the Practice Medication History Authority**. If applicable, Legal Representatives sign below: By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

______________________________ ______________________
Patient or Legal Representative's Name Date

____
Patient or Legal Representative's Signature

For Clinic Use Only: Health Record ID Number _____________________

Reviewed: November 11th, 2017

People's Community Clinic of Newberg
Sheila M. Smith, FNP-BC
(503) 449-8988 phone • (503) 894-9194 fax

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Instructions

Please read and agree to the below attestation, and list your previous healthcare provider or facility/hospital that you would like us to get your records from. Please limit this request to one provider/facility per form; you may use more request forms if necessary.

I desire to release the medical information for the patient indicated below for the purposes of establishing and coordinating care and updating records maintained with Sheila M. Smith FNP-BC. I understand that my establishing or receiving medical care is not contingent upon signing this form. **I understand the release of this information is intended to assist Sheila M. Smith and People's Community Clinic of Newberg to care for the patient indicated below.**

I understand this authorization may be revoked in writing at any time by providing a written statement to the address above. No revocation will be retroactive pertaining to records already released. **This authorization will expire exactly 1 year from date of execution.**

I understand the information used or disclosed may be subject to re-disclosure except for highly confidential information to include "Sensitive Information". The undersigned hereby releases Sheila M. Smith and People's Community Clinic of Newberg from any liability which may arise from the release and/or examination of the information indicated above. **I have read this authorization, and I understand it.**

I authorize ____________________________________ to release a copy of medical information
(hospital, facility or health care provider)

for: ___________________________________ ___________________ ___________________
(name of patient) (date of birth) (telephone number)

for the purpose of: _____ Patient Care _____ Other: ___________________________

to: **Sheila M. Smith, FNP-BC, phone (503) 449-8988; fax (503) 894-9194**

By placing my initials below, I indicate my approval for the release of the following medical records (*for the past 5 years*), if such exist, to be sent.

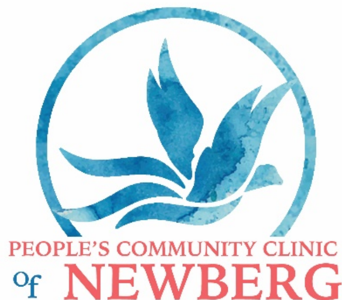
_____ Office Visit Notes / Chart Summaries _____ Lab and Diagnostic Results

_____ Current Medication List _____ Other: _____________________

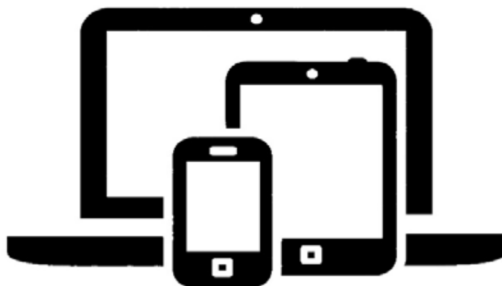
_____ I understand the information in my health record may include "Sensitive Information" information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____ _________________________
Signature of Patient or Person Authorized by Law Date

Relationship to Patient: _____ Self _____ Parent/Legal Guardian _____ Personal Representative



Patient Portal Signup



Do you use a smart phone, tablet or computer to go online and check email? Then we have a great opportunity for you!

By providing your email address, you can sign up for our **Patient Portal**, allowing you online access for medical questions, refill requests, test results and appointment scheduling.

This is a service we provide to our patients. By signing up, you will receive an invitation email with a link to set up your password. The Patient Portal is **free, optional,** and you will **NOT** receive any ads or junk mail. **Your personal health information is protected and confidential.**

______________________________	____
Patient Name	Patient Email Address
______________________________	____
Patient Date of Birth	Date

Reviewed: January 2nd, 2018