Assignments and Authorizations

Patient Name: _____ Date of Birth: _ _ /_ _ / _ _ _ _

My signature below attests that I am the ☐ **Biological/Adoptive Parent** for the patient named above and my agreement of the below terms.
☐ **Legal Guardian; or**
☐ **Foster Parent***

In order to protect the welfare of the patient, if any court orders/decrees/letters/contracts authorizing medical treatment exist regarding custodial/parental/guardian rights, etc., please be aware that we must maintain a copy of these documents in the patient's file.

I understand that I may be subject to legal ramifications if I purposely provide false or inaccurate information to White House Clinics. This release expires one (1) year from the date of signature; unless I choose to revoke this agreement (termination of the authorization must be received in writing).

On behalf of my minor child or other patient named above,

CONSENT TO TREAT

I hereby give my permission to White House Clinics (referred to as "WHC" in this form) for the evaluation and treatment of the presented medical, dental, and/or behavioral health condition (herein referred to as "health care services"). I am requesting that health care services be provided to my minor child or the patient named above at WHC. I voluntarily consent to all treatment and health care services that the caregivers at WHC consider to be necessary for the patient named above. These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell the WHC caregiver. My minor child or other above-named patient's blood may be used to perform routine quality assurance testing. WHC complies with all laws allowing minors to consent for treatment without parental consent. I am aware that the practice of medicine, dentistry, or behavioral health are not an exact science; no guarantees have been made to me about the results of treatments, examinations, or services.

FINANCIAL RESPONSIBILITY

Subject to applicable law and the terms and conditions of any applicable contract between WHC and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the above-named patient, I agree to be financially responsible and obligated to pay WHC for any balance not paid under the "Assignment of Benefits" paragraph below. Subject to applicable law, and in consideration of all health care services rendered or about to be rendered to the above-named patient, I agree to be financially responsible and obligated to pay WHC for the patient balances due.

ASSIGNMENT OF BENEFIT

In consideration of all health care services rendered or about to be rendered to the above-named patient, I hereby assign to WHC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding WHC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by WHC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer. I understand that my current insurance must be on file with WHC for my insurance to be billed and as such I will be asked to present my insurance card at each visit to verify my insurance coverage. If I do not provide WHC with accurate insurance information I will be considered a self-pay patient and obligated to pay all fees associated with services rendered.

CONSENT TO RETRIEVE MEDICAL INFORMATION

As a patient of WHC, I authorize WHC to retrieve and use my minor child or other above-named patient's medication history from SureScripts, an electronic prescriptions network. This is an electronic way for WHC to access patient prescription benefit information and patient medication history. WHC can only retrieve medication history from offices that support SureScripts. Utilizing this method is the best way to obtain the most up to date information so that the healthcare provider can deliver the best care to your minor child or other named patient above.

Assignments and Authorizations

NOTICE OF PATIENT GUIDE

I acknowledge receipt of the WHC Patient Guide. The Patient Guide is an introductory brochure to WHC and explains WHC policies and practices. I understand that this information is provided so that I may be better informed about WHC operations and actively participate in the care of my minor child or other named patient above. If I do not understand any portion of this brochure I may ask for clarification from any WHC staff member. I understand that taking photographs and/or recording of any type is prohibited unless express permission is granted by WHC.

NOTICE OF PRIVACY PRACTICE

I have received a copy of the WHC Notice of Privacy Practices. The Notice of Privacy Practices explains how WHC may use and disclose confidential health information that identifies me (or the above-named patient). I consent to let WHC use and disclose health information about me (or the above-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the above-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by WHC, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent WHC or provide assistance to WHC for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above named patient's) health care, including for substance use, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that WHC has already relied on my consent. I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to WHC or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from WHC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered, including marketing messages/calls. I understand this consent to communications is not required to receive services from WHC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

FOR BIOLOGICAL/ADOPTIVE PARENTS ONLY

You may list in the space provided below, individuals who are given permission to consent for treatment for the patient listed above and have the same access to the patient's medical records, including the right to disclose the contents to others:

Authorized Individuals:	Relationship to Patient:
_____	_____
_____	_____

FOR MINOR PATIENTS 16 YEARS OF AGE OR OLDER

☐ I authorize the minor patient referenced above to seek care and treatment, including vaccinations, without a parent/ guardian present (except for sports or school physicals).

_____	_____
Patient/Legal Guardian Signature	Relationship to Patient
_____	_____
Telephone Number	Date
_____	_____
Witness Signatue	Date

*Foster parents are exempt from Consent to Treat, Financial Responsibility, and Assignment of Benefit when care is provided while child is in custody of DCBS as outlined in the DPP – 106A Form by the Cabinet for Health and Family Services.