DATE STAMP
03/16/2023

Finger Lakes COMMUNITY HEALTH
Taking the time to care.

AUTHORIZATION FOR TREATMENT

THIS IS A LEGAL DOCUMENT

AUTHORIZATION FOR TREATMENT

If you or your dependent needs any medical, dental, family planning or hospital services in New York State you must give your permission. This authorization form will allow us to provide the services for you or your dependent. In the case of an emergency, authorization is not necessary.

I hereby authorize the medical/dental/family planning staff of the Finger Lakes Migrant Health Care Project, Inc. to provide care to myself/or my dependent.

ASSIGNMENT OF BENEFITS

I authorize the Finger Lakes Migrant Health Care Project, Inc. to submit claims on my behalf to my insurance carrier and for payment to be made directly to the Finger Lakes Migrant Health Care Project, Inc. for services rendered to me or my dependent. A copy of this authorization may be used as signature for assignment of benefits. I understand that I am financially responsible for all chargers whether or not covered by my insurance company. All insurance copays are due at the time of service.

I understand that if I chose not to assign payment to the above named facility by means of changing my Primary Care Physician (PCP). I am responsible to pay the entire balance due at the time of service.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process any claims submitted on me or my dependent's behalf by the Finger Lakes Migrant Health Care Project, Inc. A copy of this authorization may be used in place of the original.

I authorize Finger Lakes Migrant Health Care Project, Inc. to discuss my billing information in my absence with _____ whose phone number is _____.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICE

I acknowledge that I have received a copy of the Finger Lakes Migrant Health Care Project, Inc. current Notice of Health Information Practices on the date set forth below.

DISMISSAL POLICY

I understand that I may be dismissed from medical, dental and/or family planning services at any of the Finger Lakes Migrant Health Care Project, Inc facilities for Persistent failure to keep necessary scheduled appointments, abusive behavior, persistent refusal to follow medical advice, non-payment, and abusive behavior while under the influence of drugs or alcohol.

_____ _____

Print Patient Name

Patient Signature (if the patient is 17 and under the parent or guardian must sign)

Date _____