Big Lake Clinic

Admission Consent

I request that services and care be furnished to me by Big Lake Clinic (“clinic”) and:

1. **General Consent for Treatment**
   I hereby agree to the performance of such procedures and treatments that in the opinion of the attending/consulting physician/provider are deemed necessary.

2. **Release of Information**
   A. Health Information includes transfer records, medical records, financial and other information. I authorize the Big Lake Clinic to release information about me as follows:
   B. To all third party insurance carriers, health service plans or health maintenance organizations or third-party administrators. This release of information is necessary to determine payment of my clinic bill, payment of claims, and/or fraud investigation.

   C. For quality of care review studies.

   D. To health care providers for my continuing patient care and billing purposes.

   E. For purposes of medical or scientific research, I am hereby notified that health records may be released for such purposes, unless I object. If I object, my health records will not be released. I may revoke this authorization at any time in writing.

   F. Incidental and limited release of information to independent contractors and technicians in order to repair information systems. Such independent contractors sign a confidentiality agreement prior to access.

   G. I understand that my medical record at Big Lake Clinic is part of the CentraCare Health System’s (CCHS) Electronic Medical Record. CCHS provides both CCHS and non-CCHS organizations access to this integrated Electronic Medical Record System. This access is secure and provides improved patient care, patient safety, and the coordination of care across the region. A list of these non-CCHS organizations will be provided to the patient upon request.

   H. I understand certain circumstances require disclosure of information to organizations such as health departments or the Centers for Disease Control and Prevention. This may include cases of HIV, tuberculosis, viral meningitis, and other diseases.

3. **Assignment of Insurance Benefits and Guarantee of Account**
   A. For services provided by the clinic to me, the undersigned personally guarantee payment to the bill of the clinic incurred as a result of health care service. This included services, which for any reason are not paid by insurance, government programs, or other third-party sources.
   B. I request payment for authorized Medicare, Medicaid, and/or health insurance benefits for all services furnished me by Big Lake Clinic. I authorize payment directly to the clinic of insurance, Medicare, Medicaid benefit, or other funds the patient or I are entitled to receive from other sources for payment of services provided to me.

4. **Applicability to Other Providers**
   I hereby make the above consents/authorizations/assignments/guarantees applicable to other providers furnishing service to me while receiving care from Big Lake Clinic, and to providers for whom the clinic, by agreement, provides information and services for their billing and patient care purposes, whether by electronic database or otherwise.

Signature of patient/authorized representative/relationship	Date