Gentle Care Health Center
Ellen C. Spinner, MSN, CNP
15 North Main Street
Mechanicsburg, OH 43044

Consent For Treatment Payment Health Care Operations

This health care facility will use your health care information for the following reasons:

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health insurance carrier, or from another insurer for services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purposes of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

I _____, do hereby agree to allow any healthcare information to be used for the purpose of treatment, payment, and health care operations.

_____ _____
Patient Signature **Date**

_____ _____
Patient Representative and Relationship **Date**

Authorization and Release

Please check one of the following:

☐ **I certify** the above information is true and correct to the best of my knowledge**. I have insurance coverage** and assign all insurance benefits directly to the provider. I agree that I am ultimately responsible for payment- and that at this time services rendered **may not** be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.
☐ **I certify** the above information is true and correct to the best of my knowledge**. I** certify that I (or my dependent) **do not have insurance coverage** at this time. I understand and agree that I am financially responsible for all charges rendered.

_____ _____ _____
Patient/Responsible Party Signature **Relationship** **Date**