Foothills Health & Wellness Center

A program of Kentucky River Foothills Development Council, Inc.

Assignments and Authorizations

My signature below indicates my acceptance & agreements of the following:

CONSENT TO TREAT

I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of the Foothills Health & Wellness Center and its medical staff, or their designees, as may in their professional judgement be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am dully authorized to make such decisions, including the right to refuse medical and surgical procedures.

GUARANTEE OF PAYMENT

I agree to be responsible to Foothills Health & Wellness Center and/or their assigns for charges resulting from services rendered at the prevailing rate. I understand all bills are due in full upon demand. I also understand that payment plans are available upon request should I need assistance in making payments toward any outstanding balances. I realize that if payment is not received within 120 days, that I can be terminated from the clinic. Should I fail to honor this agreement, or any payment plan agreements, I agree to pay any collection costs or attorney fees resulting from the collection of our/my account.

ASSIGNMENT OF BENEFIT

I assign all rights and privileges and authorize payment directly to Foothills Health & Wellness Center, and/or their assigns for any claim filed on my behalf. I also understand that I am financially responsible for any charges not covered or paid by my insurance company.

NOTICE OF PRIVACY PRACTICES

Kentucky River Foothills Development Council, Inc. (KRFDC) recognizes and abides by the newly enacted federally mandated Health Insurance Portability & Accountability Act, (HIPAA). KRFDC's Foothills Health & Wellness Center, as a health care provider, will strive to protect all patient information from outside requests for information, as well as, the protection of patient information from employees and staff by ensuring protocols are implemented to fully comply with the HIPAA standards. Foothills Health & Wellness Center strongly encourages all patients to read the Notice of Privacy Practices. If you cannot understand the Notice of Privacy Practices, notify a member of our staff, who will assist you.

I acknowledge that I received a copy of the Notice of Privacy Practices and understand that Foothills Health & Wellness Center will use and disclose my health information as described in the Notice.

______________________________	______________________________
Patient/Legal Guardian Signature	Relationship to Patient
______________________________	______________________________
Printed Patient Name	Witness Signature
______________________________	______________________________
Patient Date of Birth	Date