Haak'u Health Center

80 B Veterans Blvd Pueblo of Acoma, New Mexico, 87034
PO Box 40 San Fidel New Mexico, 87049
Telephone (505) 552-5300 ~ Fax (505) 552-5478

Patient Service Agreement Form

1. RELEASE OF INFORMATION AND ELECTRONIC HEALTH INFORMATION EXCHANGE

Haak'u Health Center (HHC) may disclose all or any reasonable part of the patient's electronic medical record to include information pertaining to medical history mental or physical condition, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing or continuation of care to include, but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit for any purposes reasonably related to these activates. I understand that this authorization will remain for 1 year from the date signed.

2. ACKNOWLEDGEMENT OF RECEIPT OF HHC NOTICE OF PRIVACY PRACTICE .

I acknowledge that I have received the Notice of Privacy Practices. Haak'u Health Center (HHC) Notice of Privacy Practices provides information about how we may use and disclose protected health information.

3. PATIENT RIGHTS AND RESPONSIBILITY

HHC is committed to providing quality healthcare. It is our pledge to provider this care with respect and dignity. Therefore, I acknowledge I have received the Patient Rights and Responsibilities form. I accept my rights and responsibilities commit to upholding my patient responsibilities in effort to obtain the best treatment and services provided by Haak'u Health Center.

4. AMERICAN INDIANS/ALASKA NATIVES

Haak'u Health Center regulations require all patients to provide proof of Tribal Membership with a federally recognized tribe. Eligibility to receive medical services are determined by verification of tribal enrollment. Patients who do not have tribal enrollment information in their medical file are required to provide this information within 30 days. The Certificate of Indian Blood or other tribal enrollment identification is accepted as proof of Indian Blood. You hereby acknowledge the responsibility to provide Proof of Indian Blood. HHC reserves the right to postpone the scheduling of appointments beyond the 3rd visit if the CIB is not submitted to Patient Registration or Medical Records. Information on tribal enrollment may be provided to you by your respective tribal offices and/or agencies.

5. MEDICAL PHOTOGRAPHY

I consent for medical photographs to be taken of me by any HHC provider. I understand that the information may be used in my medical records and/or for purposes of medical teaching. I understand that I will not receive payment from any party.

6. ASSIGNMENT OF BENEFITS

Private Insurance/ Medicaid/ Medicare

I authorize the release of any medical or other information necessary to determine benefits payable for related services rendered at Haak'u Health Center (HHC) by my insurance carrier. Haak'u Health Center (HHC) may disclose all or any part of the patient's protected health information (PHI) to other medical entities including, but not limited to, hospital or medicals services companies, insurance companies, workmen' compensation carriers, welfare funds or the patient's employer.

I hereby assign to the Haak'u Health Center (HHC) such insurance benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me by the HHC valid for one year from the date listed below. I authorize payment to such benefits (if any) directly to HHC. I understand that this assignment applies to Medical, Dental, Behavioral Health, Optometry, Pharmacy and any other services and supplies furnished to me during the period designated. Releases of protected health information (PHI) to substantiate appropriate insurance claims are authorized.

7. Purchase Referred Care (PRC):

I understand that PRC is not an insurance or an entitlement program. I will notify PRC within 72 hours if I visit any ER or Urgent Care facility and I will obtain a referral from my HHC Provider for any special services outside of HHC.

I have read and understand the contents above. Interpretation of this agreement was explained to me in English and/ or in my native language.

_____	_____	_____	_____
Patients/ Legal Guardian Signature	Patient Name (Print)	Date of Birth	Date
_____	_____	_____	
HHC Witness Signature	Date	Chart #	