MOSAIC
Health & Healing Arts

Consent to Medical Treatment, Signature on File, Assignment of Benefits, Financial Agreement and HIPAA Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- I am requesting medical and/or mental health treatment from the Providers/Interns/Students at the practice.
- I authorize the practice to have access to my medication history.
- I agree to pay all applicable co-insurance payments at the time of service and will promptly pay the portion of my bill that this office is allowed to collect after my insurance has paid its part.
- I understand that I may have a copy of the collection policy if I wish.

_____	_____
Patient Name	**Responsible Party's Name**
_____	_____
Patient's Signature	**Responsible Party's Signature**
_____	_____
Date	**Date**

For Office Use Only:

Patient/Responsible Party failed to sign form on: _____

Reason: _____