



PATIENT/CHILD NAME (PRINTED) _____
PATIENT/CHILD DATE OF BIRTH _____ TODAY'S DATE _____

Protected Health Information (PHI) Agreement & HIPAA Acknowledgement

Please read and sign below

New Kingdom Healthcare will examine, test, diagnose, treat, or refer their patients to provide quality healthcare. Patients' "protected health information" (PHI) is used to decide on what services to provide and how best to direct your treatment options. This information may be used to arrange payment for your treatment with insurance agencies or other financial organizations, for government functions, or to help provide other treatment or services outside of this facility. We maintain, protect, and exchange your PHI in accordance with state and federal standards, including Health Insurance Portability and Accountability Act (HIPAA) which is specific to the security of electronic PHI.

Other than the billing/insurance process or the specific referral process when requested/agreed by patient, information will not be shared outside of the clinic without additional patient permission.

You have the right to review New Kingdom Healthcare's privacy notice. You have the right to revoke the **Protected Health Information Agreement & HIPAA Acknowledgement** form in writing to New Kingdom Healthcare.

Consent to Use and Disclose Your Health Information

By signing below, you certify that you are familiar with the Health Insurance Portability and Accountability Act (HIPAA) and consent to the use of your PHI as described above.

→ PATIENT/PARENT SIGNATURE _____

CONSENT FOR TREATMENT & ASSIGNMENT/RELEASE OF BENEFITS

Please read and sign below

- I consent to attending my medical visit and receiving recommendations from my provider, understanding I have the opportunity to discuss risks and benefits of those medical recommendations - including medications, therapies, testing, and/or referrals.
- I (signed below) certify that I (or my dependent) have insurance coverage as provided and assign all insurance benefits (if any) directly to New Kingdom Healthcare and its providers for services rendered.
- I hereby authorize New Kingdom Healthcare to release all necessary information to the insurance company to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance documents.
- I understand that I am financially responsible for all charges whether paid by insurance or not.
- The privacy of our patients is of the utmost importance to New Kingdom Healthcare, therefore, our internal policy forbids the recording of a visit without the express permission from the provider prior to the visit

→ PATIENT/PARENT SIGNATURE _____