Northern Apache County Special Health Care District
St. Michaels Clinic and Sanders Clinic

CONDITION OF TREATMENT

1. **AUTHORIZATION FOR TREATMENT**
   I voluntarily agree to treatment and services that my clinician deems necessary. There are certain procedures for which special consent will be obtained.

   _____ *Initial*

2. **AUTHORIZATION FOR E-PRESCRIBING(**electronic transmission of prescriptions**)TO PREVENT PRESCRIPTION ERRORS**

   _____ *Initial*

3. **RELEASE OF INFORMATION FOR BILLING SERVICES AND REVIEW**
   NACSHCD may disclose all or any part of my record, including information pertaining to my mental and physical condition, to any person or entity or the purpose of billing, insurance company requirements, pre-procedure/visits review, or for other purposes related to these activities.

   _____ *Initial*

4. **FINANCIAL AGREEMENT**
   I understand that NACSHCD **does not** receive payment from the *Indian Health Services*. I also understand that there may be charges not covered by my insurance, AHCCCS, Medicaid or Medicare for which I am responsible. I understand that in addition to the charge(s) by NACSHCD for drawing blood or collection of specimens I may receive a bill from the Laboratory for tests ordered by my clinician. I understand that NACSHCD contracts with AS Medication for medications and that AS Medication does not accept all the insurance plan accepted by NACSHCD.

5. **ASSIGNMENT OF BENEFITS**
   I hereby authorize payment directly to NACSHCD of the health care payment benefits otherwise payable to me but not to exceed the clinic's regular charges for services.

   _____ *Initial*

   _____ *Initial*

6. **AUTHORIZATION FOR REVIEW OF MEDICATION(S)**
   I give my consent for review of my medication(s) from all sources.

   _____ *Initial*

_____ _____
PRINT PATIENTS NAME **DATE**

_____ _____
PATIENT SIGNATURE **WITNESS**

_____ _____
PARENT/ GUARDIAN SIGNATURE **WITNESS**