

Nooksack Tribal Health Center

2510 Sulwhanon Dr.

Everson, WA 98247

(360) 966-2106

PATIENT NAME: _____

DATE OF BIRTH: _____

ASSIGNMENT OF BENEFITS: _____ (Initial)

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Nooksack Indian Tribe for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. Should I receive any payment, meant for Nooksack Health Clinic, it will be turned into the clinic immediately.

AUTHORIZATION TO RELEASE INFORMATION: _____ (Initial)

I hereby authorize Nooksack Health Clinic to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoke by me in writing.

I have requested medical services from the Nooksack Health Center on behalf of myself and/or a dependent, and understand by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

If I am a direct only patient, I understand I will be obligated to pay for any services not paid for by my insurance. I accept financial responsibility to Nooksack Health Clinic for 100% of charges. I understand I may personally be responsible for financial costs in accordance with Nooksack Health Clinic policies and procedures.

A photocopy of this assignment is to be considered as valid as the original.

NOTICE OF PRIVACY PRACTICES: _____ (Initial)

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Medical Records Clerk.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information.

Patient / Responsible Party Signature

Date & Time