MRN_____

American Indian Health Service of Chicago, Inc.

4326 West Montrose, Chicago, IL 60641

PATIENT SERVICE AGREEMENT

RIGHT TO REFUSE SERVICES

American Indian Health Service of Chicago reserves the right to refuse services to anyone for cause which includes but is not limited to belligerent or abusive behavior; failure to comply with all third party payer processes (Indian Health Services is considered the payer of last resort); non-compliance with treatment; or any other violation of the Patient's Rights and Responsibilities.

PAYMENT FOR SERVICES AT AN OUTSIDE HEALTH CARE FACILITY

If you go to another health facility for services or receive a referral from an American Indian Health Service of Chicago provider to go to another health facility, please be advised that "YOU" are responsible to pay for cost of this care. If you have an alternate resource such as Private Insurance, Medicare or Medicaid, you are responsible for providing this information.

CONSENT TO TREAT

The undersigned hereby gives consent to the staff of American Indian Health Service of Chicago for medical examination, treatment, laboratory services and professional services including, but not limited to Behavioral Health Services to the undersigned and/or minor child listed below.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION FOR BILLING

I understand that under the Indian Health Care Improvement Act Amendments, Public Law 100-713, American Indian Health Service of Chicago is the "payer of last resort" and required by Federal law to seek and collect payment from any medical program that my minor children or I may be eligible to participate in. I acknowledge that applying for benefits (i.e. Medicaid) and providing my insurance information is my financial responsibility to American Indian Health Service of Chicago and is required in order to receive services. I hereby assign all benefits for services rendered to American Indian Health Service of Chicago and I understand that payments will be made directly to the clinic. I hereby authorize the release of any and all medical information necessary to process my claims. Fee information may be provided upon request.

X _____ Initials

MAINTAINING "CURRENT MEDICAL PATIENT" STATUS

A "Current Medical Patient" is considered to be a patient who has been seen by a medical provider within the last year. By law, prescriptions *with refills* expire after one year. (Prescriptions for pain medication expire sooner) In order to continue receiving medication you must follow the practitioner's treatment plan and keep your appointments. If you have not been seen in over one year you will not be able to receive prescriptions.

PATIENT HANDBOOK

I hereby acknowledge receipt of the AIHSC Patient handbook that outlines Patient Rights and Responsibilities and additional departmental information.

NOTICE OF PRIVACY PRACTICES

- ☐ **I have been offered and accept receipt of the AIHSC Notice of Privacy Practices.**
- ☐ **I have been offered and decline receipt of the AIHSC Notice of Privacy Practices.**

PRIVACY ACT ACKNOWLEDGEMENT

I have read the Privacy Act Notice. I have been informed that my record is or will be kept in the Health and Medical Records System at: **American Indian Health Service of Chicago, 4326 West Montrose, Chicago, IL 60641**

I understand that the information given by me and/or collected and stored in my health record is necessary for AIHSC staff to provide services for my health and well-being. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person, unless specified as "operations use", without my consent.

_____

Patient's Name (PRINT)

X _____ _____

Signature of Patient (or Parent/Legal Guardian for Minor) **Date**