



*Mat-Su Health Services, Inc*

Consent for Treatment

I consent to receive services by the team of healthcare professionals at Mat-Su Health Services (MHS). I understand that my health information may be shared between the Primary Care Clinic and the Behavioral Health Services program in order to coordinate my care.

Financial Responsibility

I understand that MHS will, as a courtesy to me, bill my insurance based on the information I have provided. I will pay for services denied by my insurance, Medicaid, or Medicare. I will pay any co-pays, deductibles, or amount not paid by my insurance at the time I receive the service.

I authorize MHS to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment to the Social Security Administration, Centers for Medicare and Medicaid Services, my insurance company, or any intermediaries, carriers, and agents. Also, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of payment apply.

I understand that MHS offers a fee discount program. In order to take advantage of any discount programs, I must provide proof of income on at least an annual basis\* or sooner if my income changes. If I fail to provide proof of income in a timely manner, I will be responsible for full fees. I understand that I am responsible for all charges, fees and costs associated with the services I receive.

Acknowledgement Statements

I certify that the information I provide to MHS, including my insurance, contact, income, and other financial benefit information, is, to the best of my knowledge, current, true, and accurate. I will inform MHS about any changes to my insurance, income, other benefits, or contact information.

I acknowledge that I have been offered a copy of MHS Notice of Privacy Practices, which states how my health information may be used and/or disclosed. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. If I am not the person receiving healthcare services, I represent that I am authorized by law to act for and on that person's behalf.

I understand that I may request a copy of MHS Individual Rights and Responsibilities.

I understand that MHS has a No Show policy which states that I must notify MHS by 4:00pm the business day before my appointment if I need to cancel the appointment. If I do not notify MHS, or am late to my appointment it will be counted as a No Show. After three (3) No Shows, I will be unable to schedule appointments. However, I have the option of being seen on a walk-in basis, if a provider is available.

**My signature below indicates that I have read and understood the above information concerning receiving services at MHS.**

\_\_\_\_\_  
Individual Receiving Services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

*\*Your Proof of Income was accepted on \_\_\_\_\_, therefore you will need to update your income with us no later than \_\_\_\_\_*