SouthEast Alaska Regional Health Consortium
AUTHORIZATION FOR TREATMENT AND PROMISE TO PAY *(ASSIGNMENT OF BENEFITS)*

AUTHORIZATION

I authorize and consent to my admission or treatment as a patient at SEARHC for all treatment, and evaluation including any diagnostic and therapeutic care recommended by my physician or other health care provider. I acknowledge I have been separately informed by my physician or other health care provider and understand the proposed treatment, the risks inherent in the proposed treatment, and any alternatives to the proposed treatment. I understand I have the right to make decisions concerning my plan of care, to refuse medical care, and to obtain information about my health needs and treatment from my physician or other health care provider.

PROMISE TO PAY

I authorize any third party insurance benefits to be paid directly to SEARHC. I understand I am financially responsible for any services not covered by my insurance company.

I assign to SEARHC all insurance proceeds for medical services rendered, and I understand SEARHC does not assume responsibility for the collection of such proceeds. If my account becomes delinquent (90 days after services have been provided) and is assigned to a collection agency, a collection fee will be added to the delinquent balance.

Eligible Alaska Native/American Indian (AN/AI) beneficiaries (with documented eligibility) will not be financially responsible for covered services. AN/AI beneficiaries (with documented eligibility) without third party insurance will be financially responsible for services not covered by SEARHC. These include, but are not limited to: eyeglasses, hearing aids, some dental services, and medications not included in the SEARHC Medication Benefits Package.

INJURY RELATED CLAIM

In the event of any injury, I authorize care and treatment for the person named below and agree to pay all fees and charges for such treatment as shown by statements for services rendered by SEARHC. I will not delay or withhold payment because of pending claims for insurance coverage.

SEARCH OF PATIENT AND BELONGINGS

I understand , pursuant to SEARHC's policies and procedures, all patients and their belongings can be thoroughly searched immediately upon arrival for any services or hospitalization, prior to any meals, vital signs, or when the facility suspects the patient possesses any contraband, weapons, alcohol, illicit drugs, or drug paraphernalia. I understand anything brought into the facility by visitors shall be subject to being screened and confiscated. Emergency services for medical stabilization will occur prior to patient searches being performed.

This authorization will be considered valid for one (1) year from the date of signature unless otherwise noted. If the below names is a minor, as the parent/legal guardian, I authorize medical care for the health and well being of this minor.

______________________________________ __________________________

Signed by responsible party (Patient, Parent, Guardian) **Date**

CONTINUED ON BACK

Office Use Only

Patient's Printed Name: ____________________________ **Today's Date:** __________________

MPI/Health Record Number: _______________________

ENTER DATE SIGNED IN REGISTRATION,PAGE 9, FIELD 6, "ASSIGNMENT OF BENEFITS"; SCAN IN STOCKELL

The following data is needed to meet Federal funding reporting regulations for SEARHC.

1. **Race:**
   - [ ] American Indian or Alaska Native
   - [ ] Asian
   - [ ] Black or African American
   - [ ] Hispanic, Black
   - [ ] Hispanic, White
   - [ ] White
   - [ ] Native Hawaiian or Other Pacific Islander
   - [ ] Other
   - [ ] Unknown by Patient
   - [ ] Decline to Answer

2. **Ethnicity:**
   - [ ] Hispanic or Latino
   - [ ] Not Hispanic or Latino
   - [ ] Unknown by Patient
   - [ ] Decline to Answer

3. **Estimated Household Income_____________ Number in Household_____**

4. **Primary Language: ____________________ Interpreter Required? [ ] Yes [ ] No**
   Other Languages spoken: ________________________

5. **Preferred Language: ________________________**

6. **Migrant Worker: [ ] Yes [ ] No**
   Homeless: [ ] Yes [ ] No

7. **Internet Access? [ ] Yes [ ] No**
   - [ ] Home
   - [ ] Work
   - [ ] School
   - [ ] Health Care Facility
   - [ ] Library
   - [ ] Tribe/Community Center
   - [ ] Mobile Device

   Email Address: ____

8. **Do we (SEARHC) have permission to send generic health information to your email address?**
   [ ] Yes [ ] No

9. **What is your preferred method of receiving reminders?**
   [ ] Phone [ ] E-mail [ ] Mail

10. **Do you need help to hear? [ ] Yes [ ] No**

11. **Do you have trouble seeing? [ ] Yes [ ] No**

12. **Are you a Veteran? [ ] Yes [ ] No**