Name:____

Last First MI Prefers to be called/Nickname

Date of Birth: _________________ Age: ___________________ Gender Identify: _________________

Mailing Address:____

____

CITY STATE ZIP

Primary Phone:___________________________________ Secondary phone: ________________________________

CONSENT AND AUTHORIZATIONS – Please initial each item.

______**Consent for Health Care Services -** I authorize Mountain View Family Health Care, PC, designees to administer a SARS-CoV-2 antigens test. I understand that should my test result be POSITIVE, Mountain View Family Health Care, PC is required to report this to the Lewis and Clark County Health Department and I will be contact by them for additional information.

______ **Assignment for Direct Payment -** I understand that some insurance companies do not pay for routine Covid-19 screening, If my insurance should pay, I do authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my providers. I understand that I am financially responsible to the practice or my providers for charges not covered or paid pursuant to this authorization.

______**Financial Agreement –** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and of physicians/ nurse practitioners rendering services not otherwise paid by my health insurance or other payer. Any remaining charges are due upon receipt of the bill. If payment is not made within 30 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. If I default on my debt, I agree to pay all reasonable legal expenses necessary for the collection of any debt. I consent to be contacted my regular mail, by email or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well, as to the use of technology including auto-dialing and/or prerecorded messages in contacting me.

______ **Acknowledgement of Notice of Privacy Practices –** I acknowledge that Mountain View Family Health Care, PC has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also available electronically at www.helenafamilyhealth.com. I understand this acknowledgement in no way affects the care I shall receive at Mountain View Family Health Care, PC.

_______ I have been offered or accepted a copy of the Notice of Privacy Practices
_______ I have declined a copy of the Notice of Privacy Practices

---

____ _____________

Patient/Guardian Name Signature DATE