

**PATIENT CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY STATEMENT
BOYNTON HEALTH**

(Please Print)

NAME: _____

DATE OF BIRTH: _____

PATIENT # / STUDENT ID# _____

Or Patient's Label

Consent to Treatment:

I voluntarily consent to receive medical, mental health, dental and other health care services provided by Boynton Health (BH), employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the BH Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

<u>X</u>	<u>X</u>
Patient or Responsible Person Signature	Date

Financial Responsibility

It is my responsibility to make sure Boynton Health has current insurance/health plan information on file. Boynton Health will forward claims for all services provided to my insurance company or health plan. In general, my insurance company or health plan will send the payment directly to Boynton Health. Boynton Health reserves the right to withdraw care from patients if the patient/responsible person does not fulfill their financial obligation.

● **UMN (University of Minnesota) STUDENTS:**

I am financially responsible for payment of your account regardless of insurance coverage. Students typically do not receive a bill until claims has been submitted and processed by insurance. A bill is due within 30 days.

For eligible students, Student Services Fee (SSF) will provide subsidies, if applicable, after the claim is resolved. If there is a balance for services not subsidized by SSF, the amount will be billed to the student and transferred to your MYU Account if not paid within 30 days. Failure to make payment arrangements may result in a HOLD on academic records and UMN student account billing rules will apply to the amount transferred from Boynton Health. If student does not have health insurance, they will be expected to pay for services at the time of service.

● **Minneapolis College STUDENTS:**

For eligible students, Student Life Fee benefits will be applied after the claim is resolved.

● **HSA (Health Savings Account):**

HSA holders are responsible for coordinating any HSA reimbursement with their health plans prior to claims submission. All HSA plan payments received at Boynton will be applied to eligible services and are non-refundable.

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RELEASE OF INFORMATION FOR PROCESSING INSURANCE CLAIMS

I authorize Boynton Health to release the information necessary to process any applicable medical insurance claim for services provided to me at Boynton Health. I understand that Boynton Health will release copies of my medical records and information as to the nature of my treatment as requested by my insurance company or health plan. If I have designated a person other than myself as being responsible for my bills, I authorize Boynton Health representatives to disclose to the designated person, upon request, any information that would appear on my billing statement (e.g. the date of visit, the general category of service provided, and the diagnosis code).

I understand that I will be personally responsible for the payment for services not covered by my insurance, the Student Services Fee at the University of Minnesota or the Student Life Fee at the Minneapolis College.

X _____ X _____
Patient or Responsible Person Signature Date

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to be made directly to Boynton Health.

X _____ X _____
Patient or Responsible Person Signature Date

RELEASE OF HEALTH INFORMATION FOR TREATMENT

I authorize Boynton Health to release my health information to other medical, and/or mental health providers at **Boynton Health and to MHealth** for purposes of continued treatment or care coordination, including any primary care providers, referring providers or providers or facilities to whom I am referred. I understand I may revoke this authorization by written request at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once information is released pursuant to this authorization, Boynton Health cannot prevent the re-disclosure of the information to another third party.

X _____ X _____
Patient or Responsible Person Signature Date