mosaic health
Better happens together.

Patient Authorization for Treatment

Patient Name ___________________________________ **Date of Birth** ________________

Authorization for Treatment

I, the undersigned, hereby authorize medical/dental/behavioral health staff of Mosaic Health, Inc. to provide medical/dental/behavioral health care to myself or the above mentioned patient if I am executing this document as a parent or guardian. I understand that my medical record will include information regarding the medical, dental and behavioral health encounters by my Mosaic Health providers.

Financial Responsibility/Assignment of Benefits

I authorize Mosaic Health, Inc. to apply for benefits on my behalf to my insurance carrier and request my insurance company pay directly to Mosaic Health, Inc. insurance benefits otherwise payable to me. I understand that it is my responsibility to provide information regarding insurance coverage and to notify the Health Center of any changes**. I understand that I am financially responsible for any services or procedures that may not be covered by my health insurance company including co-payments and deductibles and are due on the date of service. I further understand that if I am not covered by insurance or the Mosaic Health Sliding Fee Program I am responsible for the payment of services in full.**

Authorization for Release of Information

I understand that my Mosaic Health encounters/visits are available to my Mosaic Health medical, dental and behavioral health providers to view.

I authorize Mosaic Health, Inc. to release any health information necessary as to my, or the above named patient's, diagnosis and treatment to process any claims submitted to my insurance carrier on my, or the patient's behalf. A copy of this authorization may be used in place of the original.

I authorize Mosaic Health, Inc. to forward a copy of my or the patient's health record to any provider to whom I am, or the patient is, referred for consultation. I understand that if I am, or the above named patient is, in need of a referral for community services, including the County Department of Health and the County Department of Social Services, this authorization allows the exchange of medical information with agents of those community services.

I understand that per New York mental hygiene law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

Patient Privacy Notice, Patient Bill of Rights, Standards of Conduct and Advance Care Directives

I acknowledge that I have received a copy of Mosaic Health's Patient Privacy Notice, Patient Bill of Rights, Standards of Conduct and information on Advance Directives ("Your Questions Answered" Brochure, NYS Dept of Health "Deciding About Health Care" Guide and Health Care Proxy form).

I grant my permission to Mosaic Health, or its assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above, or it has been read to me, and I fully understand these statements.

______________________________ ______________________________

Patient/Parent or Guardian Signature | Printed Name/Relationship to Patient

______________________________ ______________________________

Witness | Date