Annual Authorizations Form

AUTHORIZATION FOR RELEASE OF INFORMATION FOR BILLING ONLY AND MANDATED STUDIES

I authorize Sadler Health Center Corporation to release such information as may be necessary for the completion of insurance claims relative to my services. I understand that Sadler Health Center Corporation may disclose and release any or all of my medical record to any person or corporation which is or may be liable under a contract to Sadler Health Center Corporation, to the patient or family member, or to the employer of the patient for all or part of the provider's charges. Sadler also may release data including identifying information when required by law and/or Federal/State study mandates or requirements. If the patient is eligible he/she will be entered into the Vaccines for Children (VFC) Program.

HIPAA

1- I acknowledge receipt of Sadler Health Center's Notice of Privacy Practices and the Patient and Center Rights and Responsibilities.
2- I authorize and allow the school nurse/ school representative and dental provider access to child's dental record.

ASSIGNMENT OF BENEFITS / NON-COVERED SERVICES / NON-PAR INSURANCE / PCP INFORMATION

1. I authorize and assign all medical, dental, and behavioral health benefits payable for services provided by Sadler Health Center Corporation be paid directly to Sadler Health Center Corporation or its Providers. In the event my insurance company forwards payment directly to me, I will deliver such payment to Sadler Health Center Corporation.
2. If any of the following apply, I may be responsible for all charges incurred.
   a. Current and correct insurance information is not present at time of service.
   b. Sadler Health Center does not participate with insurance company (unless patient presents with State Medicaid coverage on date of service)
   c. Prior notice has been given that procedure/visit is a non-covered service
   d. Sadler Health Center does not participate with MA service program listed on Promise Verification at time of service
   e. If covered by Commercial Insurance and/or PA Medical Assistance, I certify I have provided Sadler Health Center with true, correct, and accurate information in order to allow the organization to bill the appropriate payers for services I receive. I will notify the organization of any change of insurance coverage prior to future appointments
   f. I understand that payment for services may come from Federal or State funds, and that false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws
   g. Additional charges may be incurred by outside agencies for labs

I AM A CUSTODIAL PARENT OR LEGAL GUARDIAN OF THE MINOR CHILD NAMED BELOW.
I HAVE READ AND AGREE TO THE ABOVE STATEMENTS.

_____	_____	_____
Patient Name (Please Print)	Patient Date of Birth	Patient School and Grade
_____	_____	_____
Signature	Relationship to Patient	Date