SALINA FAMILY HEALTHCARE CENTER
ANNUAL ACKNOWLEDGEMENT AND CONSENT FORM

Chart #: _____

Legal Name:	DOB:
Assignment of Benefits and Authorization to Release Medical Information: I request that payment of authorized benefits from Medicare, Medicaid, and/or any insurance carrier applicable, be made to me, or on my behalf, to Salina Family Healthcare Center, for any services furnished to me and/or my dependent family members by my provider. I authorize any holder of medical/dental information about me and/or my family members to release it to the Division of Family Services, the Centers for Medicare and Medicaid Services (CMS), applicable insurer(s), and/or agent of these companies, and/or the listed responsible person(s), and information needed to determine these benefits or the benefits for other related services.	
Financial Account Policy: By my signature below, I am agreeing to the Financial Account policies set forth by Salina Family Healthcare Center. A detailed description of the Financial Account Policy is available for all patients, upon request.	
Disclosure of Insurance Coverage: I have also disclosed all insurance coverage in effect at the time services were provided to me. I understand that failure to inform Salina Family Healthcare Center of any third party insurance coverage will be considered fraud and I understand that the clinic will prosecute to the fullest extent of the law.	
Acknowledgement of Services: By signing below, I acknowledge that Salina Family Healthcare Center provides an integrated care model where behavioral health screenings and consults will be part of the patient-centered care provided.	
Patient/Legal Guardian Signature:	**Today's Date:**

For Office Use Only

Form Processed by: _____