Reproductive Healthcare of the Big Horns Signature Sheet

Name:_____ **DOB:**_____

_____ **HIPAA Notice & Patient Bill of Rights & Responsibilities:**

I have reviewed the posted Reproductive Healthcare of the Big Horns HIPAA Notice of Privacy Practices and Patient Bill of Rights and Responsibilities statements. A copy is available upon request.

_____ **Insurance Assignment of Benefits Authorization**

I authorize Reproductive Healthcare of the Big Horns to disclose medical or other information required to process claims. I understand that third party payers will be billed full price for services received. If charges are denied by insurance, a balance due adjustment will be made by RHBH according to the appropriate individual fee scale. I understand that payments from third—party payers will be made directly to Reproductive Healthcare of the Big Horns. All balances will be my financial responsibility.

_____ **Statement of Personal & Financial Inventory**

I certify that I have provided true and accurate personal and financial information to be used by Reproductive Healthcare of the Big Horns to determine my eligibility for grants and the RHBH sliding fee scale.

_____ **Consent for Services**

I am here of my own free will to receive healthcare services from Reproductive Healthcare of Big Horns staff. Services for MINORS: It is a policy directive of federal funding that all clients under the age of 18 be **encouraged to involve parents or guardians** concerning reproductive health care. Without your permission we will not discuss your services nor will we inform your parents or guardians of your visits to this clinic.

My signature acknowledges receipt, review, and agreement with all of the above information and directives.

Signature:_____ **Date:** _____