DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service
PHS Indian Health Center
Great Falls, Montana 59404

LITTLE SHELL SERVICE UNIT SERVICE AGREEMENT – AMBULATORY HEALTH CENTER

1. AUTHORIZATION FOR AMBULATORY CARE AND/OR TREATMENT: I voluntarily agree and consent to treatment and services that my provider deems necessary.
2. RELEASE OF INFORMATION FOR BILLING SERVICE AND REVIEW: I understand that Little Shell Service Unit (LSSU) may disclose all or any reasonable part of my record to include information pertaining to medical history, mental or physical conditions, alcohol/drug abuse and psychiatric diagnosis to any person or entity for the purpose of billing all or part of the clinic's charges to include but not limited to any person, insurance companies, employer, pre-admission review, utilization review, evaluation, financial audit or any purposes reasonable related to these activities. I understand that this authorization will remain in effect for the long-term period ambulatory services, unless revoked in writing prior to that date.
3. MEDICAL IMAGES: I understand that photographs, videotapes, digital or other images (medical images) may be recorded to document my care and treatment I consent to this. I understand that LSSU will retain ownership rights to these medical images, but that I will be allowed access to view them or obtain copies. I understand that these medical images will be stored in a secure manner that will protect my privacy. Images will be released or used outside LSSU only upon written authorization from my legal representative or me.
4. ASSIGNMENT OF INSURANCE BENEFITS-PRIVATE HEALTH INSURANCE: I hereby authorize payment directly to the Little Shell Service Unit, of the care benefits otherwise payable to me but not to exceed the regular charges for this period of service. Authorization is not limited to private health insurance but may include others sources such as Medicare and Medicaid, and/or reimbursable insurance for any services I receive.
5. MEDICAID: I understand that I may be asked to present my current identification card each time I receive services. I understand that I am required to submit an application for Medicaid if referred by a Physician, Benefit Coordinators or other provider.
6. MEDICARE: By signing this agreement, I have given Little Shell Service Unit a "Statement of Permit for Payment of Medicare benefits to this Provider." It is my understanding that the Professional Review Organization and its agents may receive information needed to determine benefits payable.
7. NON-BENEFICIARY FINANCIAL AGREEMENT: I understand and agree with the following: That in consideration for the services rendered to me, I am responsible to pay the bill of the services received in accordance with the regular rates and terms of LSSU. Any cost denied by an insurance agent or other responsible party, including co-payments and deductions will be my responsibility.
    - Medicaid: I understand that if I do not identify myself as a Medicaid recipient, I will be responsible for this bill. Services not paid or covered under the Medicaid program will be billed to me.
    - Medicare: You are expected to pay the Medicare deductible coinsurance. If for some reason the services received does not meet the requirement of my insurance agency, I will be responsible for the entire bill.
8. PATIENT RIGHTS AND RESPONSIBILTIES: I have read and understand the Patient Rights and Responsibilities document given to me.
9. ADVANCED DIRECTIVES: I have been informed and fully understand the options for advanced directives.
10. GRIEVANCE: I have been informed and fully understand the process for grievance concerns.
11. AGREEMENT: My signature indicates that, I agree and understand the contents of the service agreement, my rights and responsibilities as a patient, and that I have received a copy of the documents.

Signed by Patient/Legal Representative_____ Date_____/_____/_____

CHART NO: _____ DOB: _____/_____/_____ Time: _____

Revised 4/2022 TJP

INTERVIEWED AND INFORMATION UPDATED BY: _____