ACKNOWLEDGEMENT FORM

SCHEDULING POLICY

☐ As a Genesee Health Plan Provider, we would like to welcome you to our clinic. We feel privileged that you chose us to assist in your health care.

☐ Please plan to keep all scheduled appointments for clinic visits. We understand there may be unexpected events which would result in your missing an appointment. In the event that you are unable to keep an appointment please call our office at (810)424-5269 to reschedule. Missing two or more appointments without notification may result in dismissal from the clinic as a patient.

CO- PAYMENTS

☐ Genesee Health Plan - Plan B patients are expected to pay a co-payment of $3.00 with each visit. We ask that the co-payment be made at the time of your visit. If you are not aware of which plan you have, please refer to your Genesee Health Plan card. If you are a Plan A member or a Physical Therapy patient, no co-payment is required.

☐ UM-Flint students are expected to pay an office visit payment of $25 at the time of their visit. Upon request, students will be given a detailed receipt that they can submit to their insurance provider for reimbursement according to the terms of their contract. Failure to make payment will result in attempts to collect from the student account, and may impact student status if not properly addressed.

☐ Patients with no insurance or patients that choose to forgo their insurance will have a co-payment of $40 at the time of visit. Upon request patients will be given a detailed receipt that can be submitted to their insurance provider for reimbursement according to the terms of their contract.

ASSIGNMENT & RELEASE

The above-named healthcare facility may use my health care information and may disclose such information to Genesee Health Plan, Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

☐ I authorize access/use of my medical records to the following individuals.

Signature of Patient, Parent, Guardian or Personal Representative

Consent to Treat
I give the Urban Health and Wellness Center (UHWC) consent to treat.

☐ I authorize access/use of my medical records to the following individuals.

Signature of Patient, Parent, Guardian or Personal Representative

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I understand that I have a right to a copy of this acknowledgement form if I request it.

In addition to signing below, please check each box above indicating that you have read the statement next to it.

Name: ________________________________

Signature: ________________________________

Date: ________________________________