



IILIULIUK FAMILY AND HEALTH SERVICES

P.O. Box 144

34 Lavelle Court

Unalaska, Alaska 99685

Consent for Treatment/ Release of Information/ Financial Agreement

Patient Name: _____

Date of Birth: _____

Consent for Treatment: I authorize the staff at Iliuliuk Family and Health Services to provide reasonable and necessary medical examinations, testing, and treatment.

Financial Agreement: I agree to pay all fees and charges shown by statements promptly upon presentation thereof, unless credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct unless protested in writing within thirty (30) days of billing date. In the event legal action becomes necessary to collect an unpaid balance, I agree to pay reasonable attorney fees or other costs as the court determines proper.

Billing Address: I certify that the address listed on my demographic page is the correct billing address to send my billing statements. It is my responsibility to update this address as needed. I understand that my bill will be sent to collections automatically upon receipt of "Return to Sender" mail.

Appointment Cancellation: Patients are required to notify IFHS of a cancellation at least 24 hours prior to the scheduled appointment time. A fee will be charged to patients who fail to keep two or more appointments in one year without proper notice of cancellation. This charge is the patients' responsibility and not covered by insurance or workers compensation. The initial fee is \$25 and will increase by \$25 with each subsequent missed appointment. If you are more than 15 minutes late to your scheduled appointment your visit will be considered cancelled; in which case the above fee will apply.

Record Release: I authorize Iliuliuk Family and Health Services, Inc. to release my medical records to other persons or organizations for the purpose of treatment. I consent to use or disclosure of my health information to any third party responsible for payment. In addition, I give consent to disclose my, or the person named above, medical records to myself or person named below.

1. _____
2. _____
3. _____

Receipt of Notice of Medical Information: I have received the Iliuliuk Family and Health Services "Notice of Medical Information Use".

This authorization is good for two years from the date signed.

Patient/Personal Representative Signature: _____

Date/Time Signed _____