LAFENE HEALTH CENTER
COVID Vaccine
Treatment Agreement/Notice of Privacy Practices

1. I consent to the use or disclosure of my protected health information by Lafene Health Center (LHC) staff for the purpose of diagnosis or treatment, obtaining payment for healthcare services rendered, or in order to conduct healthcare operations.
2. I understand that I have the right to request a restriction or limitation on how and to whom my protected health information is used or disclosed for the above purposes. LHC is not required to agree to such a request, but if agreed upon, LHC will comply unless the information is needed to provide me emergency treatment.
3. I understand that I must present my insurance information to LHC within 30 days of the date of service or LHC may not submit my charges to insurance.
4. I understand that LHC does not contract with all insurance companies and it is my responsibility to know if my insurance plan provides coverage for these services or requires a referral or pre-approval for such services.
5. I understand that if I do not want my insurance billed for specific services, I must notify LHC the same day of service.
6. I understand that I am financially responsible to LHC for any charges, copays and deductibles not covered by my insurance plan. And, I understand that if I do not pay my bill within 60 days of my date of service, my overdue account will have a hold put on it from the University, preventing me from drop/adding, enrolling, and receiving transcripts.
7. I understand that LHC is not a contracting provider for and cannot bill KanCare, Medicare, Medicaid, or Healthwave. If I have these types of government health benefits, I am responsible for paying all LHC charges, and it is my responsibility to seek reimbursement from these programs.
8. I further authorize LHC to file any mandatory reporting to the State as required by State law.
9. I give my consent for immunization information to be released to the Kansas Immunization Program for the purpose of assessment and reporting.
10. I understand if I make an appointment and then fail to keep the appointment without notifying LHC, I will be assessed a failed appointment charge.

YOUR WID# OR DATE OF BIRTH: _____

PRINT YOUR FULL NAME: _____

By signing below, I agree to the Treatment Agreement and reviewed the Notice of Privacy Practices.

Patient Signature_____ Date_____