MID DAKOTA CLINIC | MDC
The doctors you know and trust.℠

Patient Notice and Assignment of Insurance Benefits

USE AND DISCLOSURE OF MEDICAL INFORMATION

Mid Dakota Clinic is authorized by law to release or receive a patient's medical information to or from healthcare providers (i.e. physician, clinic, hospital, pharmacy, etc.) involved in a patient's care; to release such information as may be necessary or required for statistical reporting or as required by applicable law; to obtain patient medication history information; and to release medical information necessary to process claims, insurance reviews, pre-authorizations and case management to any person or corporation which is or may be liable for the claims charges.

Mid Dakota Clinic sends immunization data to the North Dakota Immunization Information System (NDIIS) as part of your treatment. We are required by law to provide this for all children. Adult patients may elect to opt-out of submission of this data to the NDIIS by notifying their medical providers or the Clinic.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of any insurance benefits arising from policies insuring the patient, or any party liable to the patient, directly to Mid Dakota Clinic. I authorize application of any payment received by the Clinic for this period of care to any Clinic bill for which I am financially responsible that has not been paid in full at the time of the receipt of the insurance payment, subject to the rules of coordination of benefits. I understand that I am financially responsible for any charges not covered by this assignment of insurance benefits.

NOTICE OF PRIVACY PRACTICES

I acknowledge that the Mid Dakota Clinic has made a copy of its NOTICE OF PRIVACY PRACTICES available to me to read and to keep.

AUTOMATED HEALTHCARE REMINDERS

I hereby authorize Mid Dakota Clinic to deliver or cause to be delivered to me calls, messages, or text messages using an automatic telephone dialing system or an artificial or prerecorded voice, including but not limited to appointment reminders, health preventative reminders, test results, provider absences, billing and collection information, and weather-related events on my mobile phone, at the number I provided. I understand that I am not required to agree to receive such calls or messages as a condition of receiving any treatment, property, goods, or services. I also understand that my cell phone company may charge me for text messages.

I UNDERSTAND I MAY OPT-OUT OF RECEIVING SUCH MESSAGES AT ANY TIME BY INFORMING THE CLINIC, REPLYING AS DIRECTED IN THE MESSAGE TO DISCONTINUE SUCH MESSAGES, OR OPTING-OUT ON MY PATIENT PORTAL.

Patient or Authorized Signature	Relationship to Patient
Signature of Witness	Date