Section 9: Acknowledgments

On behalf of myself or the other patient named below, I acknowledge the statements made in this form:

SLIDING FEE DISCOUNT PROGRAM
I acknowledge that KANA offers a sliding fee discount program for eligible individuals. The discount categories have been explained to me and I have been given the opportunity to apply for this program.

FINANCIAL AGREEMENT
I acknowledge that any applicable co-payments, sliding fee discounts, and/or other associated charges are due at time of service, including fees for services not covered by the IHS {if an eligible IHS Beneficiary). I assign payment from my insurance directly to KANA and will update KANA on changes to my insurance information. I understand I am financially responsible to KANA for charges not paid by insurance or IHS, and the payment for those charges is due within 30 days of receiving my bill. I understand that in addition to my provider's bill, I may receive separate bills from laboratory, radiology, and other specialized services.

TELEHEALTH
I acknowledge that KANA provides certain services by remote telehealth technology. Telehealth often involves the transmission of video, audio, images, and other types of data. The remote Provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment or prescription. I understand that I may have to travel to see a Provider in-person for certain diagnosis and treatment matters. I understand that the laws that protect privacy and confidentiality of protected health information also apply to telehealth.

USE AND DISCLOSURE OF HEALTH INFORMATION
I acknowledge that I have been offered and have reviewed KANA's Notice of Privacy Practices (NPP), which describes the ways in which KANA may use and disclose my healthcare information for its treatment, payment, healthcare operations activities, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the NPP if I have a question or a complaint. I understand that I may request a copy of this notice at any time.

HEALTH INFORMATION EXCHANGE
I acknowledge that KANA participates in a Health Information Exchange, of which I can opt out at any time.

PATIENT RIGHTS AND RESPONSIBILITIES
I acknowledge I have reviewed and understand my rights and responsibilities as a KANA patient.

KANA EMERGENCY ROOM POLICY (IHS Beneficiaries)
I acknowledge I have received or have been offered a copy of KANA's Emergency Room Usage Policy.

On behalf of myself or the other patient named below, I consent to the statements made in this form:

CONSENT FOR CARE
I consent to care by the providers at KANA, which may include diagnostic procedures, treatment, communication of my information between KANA providers and programs, and such other care and services as my care team and providers consider necessary. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse plans of care, and to be told what might happen if I do. I will ask for any information I want to have about my health care and will make my wishes known. I understand that KANA participates in the training of physicians and other healthcare providers and will be told when trainees take part in my care. I intend that this consent is continuing in nature, and will remain in full force until revoked in writing.

KODIAK AREA NATIVE ASSOCIATION

HEALTH SERVICES

NOTIFICATION OF RELEASE FOR PAYMENT

I consent to KANA disclosing any diagnoses and pertinent information to the extent required to assure payment from insurance companies and any liable third-party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including medical, dental, and behavioral health; excluding, records protected by CFR 42 Part 2 under HIPAA.

USE AND DISCLOSURE OF HEALTH INFORMATION

To the extent permitted by law, I consent to the use and disclosure of my health information for the purposes described in the Notice of Privacy Practices.

COMMUNICATION ABOUT MY HEALTH CARE

By providing my phone number, I consent to employees, contractors, or other representatives of KANA, and/or any party contracted on their behalf, may contact me using automated dialing, pre-recorded script, interactive voice response, and/or text messaging technologies for health care related or account administration related communications, including but not limited to appointment reminders, prescription refill notifications, care or benefit coordination activities, collection of financial liabilities owed, and customer service or quality improvement operations. I understand that I may opt out of these types of communication methods without impacting my ability to receive care and that data usage and other charges may apply.

By signing below, I certify that I have reviewed, acknowledged, and/or consented to the terms described above. I was given the opportunity to have my questions answered, if needed, and if I have any further questions I will contact KANA for clarification.

_____

Date

_____ _____

Print Patient Name **Signature of Patient**

_____ _____

Print Parent/Guardian Name & Relationship **Signature of Parent/Guardian**