Do you have health insurance?

- ☐ I do not have any health insurance

- ☐ I do not want myHealth to bill my health insurance in order to protect my confidentiality. *If you are 18-26 or an emancipated minor you have the right to consent for mental health services on your own, and to keep your medical information private from your parents or spouse. However, if a parent or spouse is the policyholder on your insurance they may receive statements from your insurance company that show you were here and include information about the services received: this can pose a threat to confidentiality for some patients.*

- ☐ I have private health insurance through my parents or employer.
  Type/Name/Carrier: _____ member ID#:_____
  Group#:_____

- ☐ I have state medical insurance through Medical Assistance or MNCare
  Type/Name:_____ Sub ID/member ID#_____

PLEASE CHECK ONE :

- ☐ I give permission for myHealth to bill my Medical Assistance, prepaid Medical Assistance plan, or MNCare.

- ☐ I give my permission for myHealth to bill my private health insurance. If there are copays, a deductible, or if myHealth is out-of-network I understand that I may be responsible for these costs.

- ☐ I wish to be a sliding-scale fee client. I will pay what I can for my visits, and wish to complete a sliding fee contract.

Signature & Date:_____

Protected Health Information Consent

I have been given a copy of the *Notice of Health Information Practices* and understand it provides information about how myHealth may use and disclose protected health information. I understand that the *Notice* is available for me to review and that I may request another copy at any time.

I understand that myHealth may use and disclose my *protected health information* without authorization for treatment, payment, or health care operations. *Protected health information* is information myHealth creates or receives that identifies the patient, including demographic information, relating to the patient's physical or mental health, the provision of health services, and to the collection of payment for providing services.

If you understand the information in this section, please sign and date below. If you do not understand everything in this section or have questions you want answered, please speak with a myHealth staff person.

Client signature: _____ **Date:** _____