UTAH DEPARTMENT OF HEALTH
Children with Special Health Care Needs

Signature Page

Notice of Privacy Practice / Consent to Treat / Financial Agreement

Patient Name:	**DOB:**

_____ Initial

Consent to Treat

I consent for CSHCN staff to provide service(s) and treatment(s) to my child that are mutually agreed upon by me and the provider(s).

I understand that CSHCN collects and shares information with others as necessary to facilitate the mutually agreed upon services and treatment.

_____ Initial

Acknowledgment of Receipt of Notice of Privacy Practice

By signing this form, I acknowledge that I have reviewed and/or received the CSHCN Privacy Practice

_____ Initial

Financial Agreement

I authorize insurance, Medicaid, or Medicare benefits to be paid to CSHCN or its authorized agent, to release information to insurance companies, Medicaid and Medicare as necessary to process claims. I understand that I may be liable for all or a portion of the bill, as specified by Personal Financial Responsibility (PFR). I will sign over to CSHCN any amounts paid directly to the insured for services provided by CSHCN.

_____ _____
Print Name of Patient or Legal Representative Date

_____
Signature of Patient or Legal Representative

- ☐ Parent of minor child
- ☐ Self (18 or older)
- ☐ Medical Power of Attorney
- ☐ Legal Representative
- ☐ Other, explain and attach documentation _____

_____ _____
Name of CSHCN Representative (Please Print) Date