Bluestone Vista
PROVIDED BY MANKATO CLINIC
ON-SITE PRIMARY CARE

Consent for Services and Insurance
HIPAA Acknowledgement

Patient's Full Name:_____ Facility:_____

CONSENT FOR SERVICES: I consent to evaluation and treatment services determined by the physicians, nurses, or designees of Bluestone to be necessary. I consent to the use and/or disclosure of my health information by Bluestone in order to facilitate or receive payment for my treatment. I also consent to the release and disclosure of my health care information to health care providers and facilities unrelated to Bluestone that may be involved in my care.

NOTICE OF PRIVACY PRACTICES: I acknowledge I have received a copy of Bluestone's Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that Bluestone may change its privacy practices in the future and will be posted on Bluestone's web site and that I may request a copy of the new privacy practices at any time. I also understand that I can contact Bluestone's Privacy Officer with any questions I may have about the Notice of Privacy Practices.

INSURANCE CONSENT: I give permission to Bluestone to release my protected health information, including paper or electronic records of my health history, test results, diagnoses, treatment, and any plans for future care or treatment, to my Health Insurance Company or to Medical Assistance for the purposes of payment, treatment or health care operations. I understand that this information serves as a source of information for applying my diagnosis and treatment information to my medical bill; a verification to third party payers that I did in fact receive these health care services; and a tool for routine health care operations. Also, my insurer may share my past, current, and future health and account records with Bluestone about services received from Bluestone and care providers unrelated to Bluestone. These records may be used by Bluestone as needed to manage, coordinate, and to improve the quality of my care. **If I do not agree, I will check box below.**

❑ My insurer may **not** release any identifiable health records from providers unrelated to Bluestone for the purposes described above.

USE OF HEALTH CARE RECORDS IN PROGRAM EVALUATION AND TRAINING:
I give Bluestone permission to use information gathered during the course of my treatment from Bluestone, including information from my treatment records, for the purposes of program evaluation and training and for quality review of the staff performance at Bluestone.

PATIENT CENTERED MEDICAL HOME/CHRONIC CARE MANAGEMENT:
I give Bluestone permission to enroll me in the Bluestone Program, which includes appropriate physician/care management visits and activities, which will be billed to my insurance with usual copays. I understand information on these programs is included in enrollment information and on the Bluestone website and may be revoked at any time.

This consent applies to health records that my Bluestone health care providers already have about me, and information about future care I may receive from them. This consent will continue unless I cancel by giving written notice to Bluestone Physician Services or it expires as required by law. If I cancel the consent, it will apply to information generated *after the date* when the notice to cancel is received. It will not affect information that has already been shared among my health care providers

_____
Patient's Signature (or legal representative) Date

Note: *This consent must be signed by the patient, unless the patient is mentally or physically unable to sign, or is a minor.*

_____
(Legal representative - Relationship to client)

____ Physical/mental disability
___ Other
____ Minor
____ Physical or mental disability