WHITE HOUSE
CLINICS

Assignments & Authorizations

My signature below indicates my acceptance & agreement of the following:

CONSENT TO TREAT
I hereby give my permission to White House Clinics for the evaluation and treatment of the presented medical and/or dental condition.

GUARANTEE OF PAYMENT
I agree to be responsible to White House Clinics and/or their assigns for charges resulting from services rendered at the prevailing rates. I understand all bills are due in full upon demand. Should I fail to honor this agreement, I agree to pay any collection costs or attorney fees resulting from the collection of our/my account.

ASSIGNMENT OF BENEFIT
I assign all rights and privileges and authorize payment directly to White House Clinics and/or their assigns for any claim filed on my behalf for surgical, dental, physician, disability, no-fault, liability and hospital benefit insurance filed now or in the future. I agree this assignment is primary to any assignment given after this date including any cost relative to attorney fees. I also understand I am financially responsible to White House Clinics and/or their assigns for charges not covered by this assignment or not paid on a timely basis by my insurance company.

NOTICE OF PRIVACY PRACTICE
Health Help, Inc. recognizes and abides by the newly enacted federally mandated Health Insurance Portability & Accountability Act, (HIPAA). Health Help, as a health care provider will strive to protect all patient information from outside requests for information, as well as, the protection of patient information from employees and staff by ensuring protocols are implemented to fully comply with the HIPAA standards. White House Clinics strongly encourages all patients to read the Notice of Privacy Practices. If you cannot understand the Notice of Privacy Practices, notify a member of our staff, who will assist you.

I acknowledge that I received a copy of White House Clinics' Notice of Privacy Practices and understand that White House Clinics will use and disclose my health information as described in the Notice.

Patient/Legal Guardian Signature	Relationship to Patient
Print Patient Name	Witness Signature
Patient Date of Birth	Date