Consent and Release

Please read and initial each statement of consent or release.

Consent for Medical Treatment

_____ I consent to receiving medical and/or surgical treatment including, but not limited to: diagnostic tests, lab work, injections, minor operations, and removal/disposal of tissues as may be deemed advisable or necessary by the attending healthcare provider.

Consent for Behavioral Health Services

_____I consent to receiving behavioral health services as may be appropriate to assist with my medical treatment including, but not limited to: assessment of and treatment for mental health conditions and/or substance misuse.

Notice of Privacy Practices Acknowledgement

_____I authorize SRCHC to disclose my protected health information in order to carry out my treatment, obtain payment, and for health care operations such as quality reviews. I have received a copy of SRCHC's Notice of Privacy Practices (included in packet).

Release of Information

_____I authorize SRCHC to release to my insurance carrier(s) by mail, fax, electronically, or verbally, any information needed to determine benefits payable and to bill for services provided.

Informed of Ancillary Service Providers and Staff

_____I understand that from time to time, other persons may be observing or facilitating my care including, but not limited to: students of the health profession, and administrative or health care professionals in orientation or training.

Assignment of Benefits

_____I understand that this serves as a direct assignment of my medical benefits from Medicare, Medicaid, other government carrier, or any commercial/private insurance carrier, to be paid to SRCHC. **If I receive payments directly from my insurance company, I agree to bring them to SRCHC for payment on my account.**

Financial Responsibility

_____I understand that it is my responsibility to check with my insurance company to verify coverage of services. I understand that I am responsible for any deductibles, co-pays, coinsurance, non-covered services or services deemed "not medically necessary" by my insurance company. Co-pays and coinsurance will be collected at the time of service. I understand if my check is returned NSF, I will be responsible for a $25 processing fee. I understand that if I do not make my scheduled payments and/or do not make payment arrangements with SRCHC's billing department, my account may be assigned to a third party collection agency.

Referrals

_____ I understand that I may choose to receive diagnostic test(s) or health care treatment/service at a facility other than the one recommended by my health care practitioner. I understand that if I choose to have the diagnostic test, health care treatment or service at a facility different from the one recommended by my health care practitioner, I will be held responsible for determining the extent of coverage or the limitation on coverage as applicable. A health practitioner may not deny, limit or withdraw a referral solely because I choose to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health care practitioner.

I have read and agree to any section initialed above.

_____ _____

Patient or Guardian/Personal Representative signature (circle one) **Date**

_____ _____

Printed name of Patient **Printed name of Signatory and relationship, if not Patient**

3/2018