COMMUNITY HEALTH & WELLNESS PARTNERS
Care... To Live Life Fully

CONSENT TO TREAT

Patient Name (Printed) _____ Patient Date of Birth _____

I for myself do voluntarily consent to medical care, diagnostic procedures, behavioral health counseling, pharmacy or nutritional counseling services that may be done, requested or directed by or delegated in the judgment of the attending provider. I understand that I may refuse any services at any time.

I authorize release of information to all third-party payors or health and social service agencies.

I authorize release of information to Medicare and authorize Community Health and Wellness Partners of Logan County to bill my charges to Medicare.

I understand that I am still responsible for my bill even though I may have health insurance.

I understand that I will be asked to provide proof of income at least once each year, so my charges can be accurately calculated for the sliding fee schedule.

I understand that I must present a current public aid card, health insurance, or Medicare card at each visit to Community Health and Wellness Partners of Logan County when my charges are covered.

I hereby assign, transfer and set over to Community Health and Wellness Partners of Logan County all of my rights, title and interest to my medical reimbursement benefits under my insurance policies.

Community Health and Wellness Partners is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.

This notice is in compliance with the guidelines set forth in the Health Insurance Portability and Accountability Act. (HIPAA) of 1996, effective April 14th, 2003.

Signature of Patient, Parent or Guarantor _____ Date _____

Witness _____ Date _____