COMMUNICATION DIRECTIVE, CONSENT FOR TREATMENT, INSURANCE AUTHORIZATION AND ASSIGNMENT: (Must be signed and dated before treatment.)

Name: ____ Date of Birth: ______________

Please Check ☒ and enter information for preferred method of contact:

☐ Home Phone ___________________
☐ Work Phone ___________________
☐ Cell Phone ___________________
☐ Mail ___________________
☐ MSHC Online (please provide email address) ___________________

Can messages be left at any of the above? Yes ☐ ***No*** ☐

Please list all individuals that may obtain your information, including *<u>any</u>* and *<u>all</u>* legal guardians if the patient is a minor or unable to consent.

Name_____________________ Relationship _____________ Phone # ________________
Name_____________________ Relationship _____________ Phone # ________________
Name_____________________ Relationship _____________ Phone # ________________
Name_____________________ Relationship _____________ Phone # ________________

1. CONSENT TO DIAGNOSTIC TESTS, PROCEDURES, AND TREATMENT:

I consent to care involving routine diagnostic tests, procedures, and treatment as performed or ordered by the clinicians at Mid-State Health Center, including their assistants or designees, including testing for the human immunodeficiency virus (HIV) if a clinician is testing for diagnostic purposes or if there has been an exposure to health care personnel. No guarantee has been given to me as to the results that may be obtained from my care.

2. NOTICE OF PRIVACY PRACTICES:

By my signature below, I acknowledge that I have read and/or received and agree to the terms of the Notice of Privacy Practices and Patient Rights and Responsibilities from Mid-State Health Center. I also acknowledge that I have read and/or received and agree to the terms of the treatment agreement.

3. FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS:

I agree that I am responsible for payment of my bills from Mid-State Health Center and the designees. I have read and/or received a copy of the Summary of Payment and Billing Policy for Mid-State Health Center. I understand that I am solely responsible for collecting insurance claims or negotiating a settlement on all disputed claims. I also understand that any unpaid account may be assigned to a collection agency or attorney for collection, agree to the assignment of all third party payor benefits Mid-State Health Center, its clinicians, or independent providers.

I agree that a copy of this consent, release and assignment of benefits may be used in place of the original. I understand that I am entitled to a copy of same if I make such a request and that this consent release, and assignment are valid until rescinded in writing or replaced by one of a later date.

Patient Signature: ______________________________________ Today's Date: ____________________

The undersigned certifies that the patient is (unable to consent) (a minor) and the undersigned certifies that he/she has read and agrees to the above as the responsible party of the patient.

Responsible Party Signature ____________________________ Today's Date _______________________