CUSTER COUNTY MEDICAL CENTER

Patient____ Responsible Party or Legal Guardian_________________________

Consent for Services

- I consent to the provision of service encompassing examination, routine diagnostic procedures, internal audit/quality assurance procedures, nursing and other therapeutic services by the Custer County Medical Center (CCMC)/Custer County Public Health nurse. I authorize and request that the health professionals take such actions necessary and desirable in the exercise of professional judgment.
- I acknowledge that no guarantees have been made to me as to the result of examinations, treatments or therapies.
- I acknowledge that I am responsible for all charges in connection with care and treatment rendered.
- If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt.

Consent for Minor Services in Parent or Legal Guardian's Absence

- I, being the parent or legal guardian of the above-named patient do hereby authorize and consent for the minor patient to obtain treatment and for the medical professionals within the CCMC to provide medical care treatment to the minor patient in my absence.
- If I am unable to be present during the exam please allow ____________________________________ to seek medical treatment for my child (named above).

Release of Information, Payment Request and Assignment of Insurance Benefits

- I authorize payment of medical insurance benefits to Custer County Medical Center. I certify that information given to me in applying for payment under Title XVIII and Title XIX of Social Security Act is correct.
- I authorize release of all records required to act on this request.
- I further authorize release of information to obtain payment for services to family and employer upon their request.

Permission to Speak To:

I consent to the release of information/disclosures of my health information to the following person(s):

Name____ Phone Number ______________________________

Name____ Phone Number______________________________

Name____ Phone Number______________________________

- I understand that information disclosed according to this release may be re-disclosed to additional parties and no longer protected.
- I may revoke this consent at any time. I further understand that such revocation does not apply to the extent that CCMC has used or disclosed my health information and has already acted according to this release.
- I have the right to inspect and obtain a copy of any information disclosed due to this release.
- I have read and understand the contents of the above Consent for Services.
- I hereby consent to the use and disclosure of my health information as outlined in the Notice of Privacy Practices (NPP) which I have received.
- I have read and understand the contents of the Private Health Information (PHI) disclosure stated in the NPP.

I acknowledge that I am responsible for all charges in connection with care and treatment rendered within the Custer County Medical Center.

Signature____ Date____

Witness____ Date____