PROVIDENCE
Medical Institute

Treatment Consent, Understanding of Financial Responsibly and Receipt of Notice of Privacy Practices

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Last Name **First Name** **Date of Birth**

Treatment Consent: _______initial

I consent to medical and/or surgical treatment including but not limited to x-rays, laboratory tests, and other diagnostic studies as is necessary.

I agree that to the extent necessary to determine liability for payments and to obtain reimbursement, Providence Medical Institute may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable/responsible, for all or any portion of the charges incurred. This may include but not be limited to insurance companies, health care service plans, or worker's compensation carriers.

I understand that any employer requested medical care, including but not limited to pre-placement physicals, drug testing, fitness-for-duty examinations, information needed for the employer to comply with Occupational Safety and Health Administration (OSHA), Mine Safety and Health Administration (MSHA) standards or work-related injury or illness will be disclosed directly to the requesting employer.

I irrevocably assign to the doctor all payments for medical services rendered to myself or my dependents.
Returned Checks: A $35.00 charge will be applied to all returned checks for insufficient funds. A photocopy of this document is as valid and effective as the original.

Financial Responsibility: _______initial

I understand that I am liable/responsible for all charges for services and that payment is required within 30 days of receiving a bill from Providence Medical Institute. In the event that insurance eligibility cannot be verified, services will be provided with the understanding that if the services/procedures are not covered or if the insurance coverage is not in effect, I will be billed and held financially responsible for any/all services rendered; this includes any services that my insurance carrier may deem as "non covered services". I also understand that all copayments are due and payable at the time of service.

Notice of Privacy Practices: ______initial

I have received the Notice of Privacy Practices

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE:

X____

Patient or Parental/Guardian Signature (in the case of minors) Date

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Print Name Please State: Relationship to patient: [ ] Self [ ] Parent [ ] Guardian [ ] Other:_______________

Account Number_____________________________
To be completed by office staff