BOUNDARY
Community Clinics
a division of Boundary Community Hospital

Consent for Treatment

HEALTH AND MEDICAL CARE CONSENT: I give my consent to all healthcare services performed by Boundary Community Clinics, its employees, agents and affiliates, to provide such medical care (including evaluation, diagnostic procedures, and medical treatment) as may be deemed necessary and appropriate by my attending physician or surgeon, his/her assistant, or his/her designees. Boundary Community Clinics conducts training programs for healthcare professionals. These persons may be observing or participating in Boundary Community Clinics' treatment programs. They will be under the direct supervision of licensed professionals. I understand that I have the right at any time to refuse to have trainers participate in my care.

RELEASE OF INFORMATION AND INSURANCE BENEFITS: I authorize Boundary Community Clinics and my physician to release my medical and/or financial records to individuals and entities as specified in the Notice of Privacy Practices and/or by Federal and State Law. I understand that Boundary Community Clinics may also release medical information about me to physicians or other healthcare providers who may be involved in my continued care. I understand that this authorization will remain in effect for 12 months unless I revoke it, in writing. I understand that any revocation will not be effective for disclosures necessary to determine and obtain payments for healthcare that has been provided.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY: I authorize and assign direct payment of insurance benefits to Boundary Community Clinics and providers involved in my care for all amounts due from my primary and/or supplemental insurance carrier(s). I understand and agree that I am financially responsible for payment of any charges which insurance does not pay. I further understand, lacking timely payment by my insurance, I will be required to assume responsibility for payment of my account. If financial assistance is requested for payment of my account, I give my permission for investigation of my credit including consumer reports. I understand that services are provided to me, the patient, and not my insurance company. I understand and agree that I am responsible for payment of all Boundary Community Clinics' charges and the fees of other professional providers for care rendered to me at Boundary Community Clinics. By signing below, I consent to be contacted by regular mail, by email, or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide. If my bill is not paid in full, I agree to be responsible for all reasonable attorney fees and court costs in collecting any sums due and owing for services received.

ACKNOWLEDGEMENTS (PATIENTS TO INITIAL EACH ACKNOWLEDGEMENT, IF APPLICABLE):

- I acknowledge the receipt of the **Notice of Privacy Practices**
- I acknowledge receipt of the **Patient Bill of Rights and Responsibilities**
- I provided my **Ethnicity, Race and What Language I Prefer** to receive medical and healthcare instructions

I have read this form and understand its contents. I have had an opportunity to ask questions, which have been answered to my satisfaction.

_____
Print Name

_____ _____
Patient Signature Date/Time

_____ _____
Signature of authorized Representative/Parent Guardian Date/Time

_____ _____
Signature of Witness Date/Time