**Consent for Treatment**

Pt Name: ___________________________________

DOB: ______________________________________

Patient #: __________________________________

Date of Service: _____________________________

I request that Complete Health provide me and/or my family with medical care. I acknowledge my responsibility to pay for that care according to the category assigned. I also understand that if I have private insurance or Medicaid, I may still have to pay part of the fee. I authorize payment of benefits to Complete Health for services provided.

## Payment Responsibility

Payment is expected in full when services are rendered.
Regarding Medicaid and/or Medicare: I will provide my current Medicaid and/or Medicare card at each visit. If I have a share of cost, I will pay that amount at the time of service.
Private Insurance: I will provide a copy of my insurance card at each visit. If payment from the insurance company is not received by Complete Health within 120 days, I am responsible for charges. All co-pays and deductibles are due at the time of service.
Private Pay Patients: Full payment is due at that time of service. Complete Health accepts cash, checks, and credit/debit cards. I acknowledge that I have been informed about the Sliding Fee Discount program. I realize that I am responsible for any and all differences in charges and payments. I may be eligible for the Sliding Fee Discount Program but unless I bring proof of income (within 10 business days of application), I am responsible for the entire bill. It is my responsibility to inform Complete Health of any changes in my income, family status, or insurance status. I will update financial paperwork on a yearly basis. If I ask to have my account be confidential, I am still responsible for any balances I accumulate and I understand I will not receive any statements or phone calls on this confidential account. I recognize that providing Complete Health with false information will result in immediate recalculation of those fees I incurred during the fraudulent periods and all fees will be due and payable immediately.

## Notice of Privacy Practices and Patient Rights/Responsibilities

In the course of providing service, Complete Health creates, receives, and stores health information that identifies me. It is often necessary to use and disclose this health information in order to provide treatment, obtain payment, and to conduct healthcare operations. I have been offered the Notice of Privacy Practices that describes these uses and disclosures in detail. In addition, I have been offered the Patient Rights/Responsibilities detailing my own responsibilities as a patient of Complete Health.

By signing below, I acknowledge that I have received the Payment Responsibility, Notice of Privacy Practices, and Patient Rights & Responsibilities for Complete Health.

_____________________________________________________________________________

Signature Date

_____________________________________________________________________________

Signed by Relationship

If signing as a personal representative of the patient, describe the relationship to the patient.