complete HEALTH™

CONSENT TO TREAT & AGREEMENTS

Pt. #_____

Consent for Treatment

I request that Complete Health provide me and/or my family with health care. I acknowledge my responsibility to pay for that care. I understand that if I have insurance or Medicaid, I may still have to pay for part of my care. I acknowledge that I can get an estimate of charges from our Billing Department prior to services being administered but agree to pay for all services once they have been rendered. I authorize payment of benefits to Complete Health for services provided.

Patient Payment Responsibility

I understand that payment is expected in full when services are rendered, by cash, check or credit card. I will provide my current Medicaid/Medicare/private insurance card at each visit. All co-pays and deductibles are due at the time of service. I understand if payment is not received by Complete Health from my insurance provider within 120 days, I may be responsible for charges**. I understand that Complete Health offers a Sliding Fee Discount Program and that I am responsible for providing the request proof of income to qualify within 10 business days of today's visit to qualify**. I will inform Complete Health of any changes in my income, family, or insurance status. I will update this financial paperwork annually. I acknowledge that the provision of false information will result in immediate recalculation and that all fees occurring during the fraudulent period will be due and payable immediately. I acknowledge if I decline the slide and/or am at full pay that the front desk will collect a minimum payment for today's visit, and I will be responsible for any additional charges to be paid within 30 days or agree to a payment arrangement. If I choose to have my account be Confidential, I am responsible for any balances that accumulate and understand I will not be receiving any statements and/or phone calls regarding these balances.

Notice of Privacy Practices & Patient Rights/Responsibilities

I acknowledge that Complete Health will create, receive, store, and share health information that identifies me and that doing so to provide treatment, receive payment, and conduct operations within the clinic. I acknowledge that I have been offered a Notice of Privacy Practices and Patient Rights/Responsibilities detailing these uses, disclosures, and rights. Copies are also available at *completehealthsd.care*

Broken Appointments

I will arrive **20 minutes prior** to any scheduled appointment. If I cannot make my scheduled appointment, I will call or notify staff as soon as possible (ideally at least 24 hours in advance) so that my scheduled time can be provided to another patient. I acknowledge that if I miss **more than two appointments** in six months, I may need to meet with a Community Health Worker to help identify and address any obstacles I may have. If I am having transportation issues to and from my appointment, I will notify staff ahead of my appointment to discuss various available options.

By signing below, I acknowledge that I have received the Patient Responsibility, Notice of Privacy Practices, & Patient Rights & Responsibilities. I also have reviewed my registration information including my address, contact numbers, and attest they are accurate.

_____ _____

Patient Name (Printed) *Patient or Parent/Guardian Signature*

_____ _____

Patient/Guardian Name (Printed) *Date*