Heartland Community Health Clinic
. . . A Community of Caring

HEARTLAND COMMUNITY HEALTH CLINIC
CONSENT TO TREAT

I for myself do voluntarily consent to medical care or diagnostic procedures that may be done, requested or directed by or delegated in the judgment of the attending provider.

Patient Name: _____ **Patient Date of Birth**: _____
Printed Name

Signature of Patient,
Parent or Guarantor: _____ Date: _____
Signature of Patient, Parent or Guarantor

I authorize release of information to all third party payors or health and social service agencies.

I authorize release of information to Medicare and authorize Heartland Community Health Clinic to bill my charges to Medicare.

I understand that I am still responsible for my bill even though I may have health insurance.

I understand that I will be asked to provide proof of income at least once each year so my charges can be accurately calculated for the sliding fee schedule.

I understand that I must present a current public aid card, health insurance, or Medicare card at each visit to Heartland Community Health Clinic when my charges are covered.

I hereby assign, transfer and set over to Heartland Community Health Clinic all of my rights, title and interest to my medical reimbursement benefits under my insurance policies.

The above information is true and correct. This information is subject to review and verification.
I understand that I must provide written documentation to support this information; and that if I do not provide the documentation, or if I falsify information, services can be terminated.
I agree to notify Heartland Community Health Clinic of any changes in my household income information by the first appointment after the changes have occurred.

Heartland Community Health Clinic is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.

This notice is in compliance with the guidelines set forth in the Health Insurance Portability and Accountability Act. (HIPAA) of 1996, effective April 14th, 2003.

Signature of
Patient, Parent or Guarantor: _____ Date: _____

Witness: _____ Date: _____

Please provide a copy of signed Release to patient / patient representative. *CO - 2/11/13*