

GENERAL CONSENT:

1. I, the undersigned, grant permission for myself to undergo the usual tests, treatment and other procedures required in the course of study, diagnosis, and treatment for illness by the staff of Iberia Comprehensive Community Health Center (ICCHC).
2. I am aware that the practice of medicine and dental medicine is not an exact science, and I acknowledge that no guarantees of a cure have been made to me as a result of examinations or treatments by ICCHC.
3. I give permission to release to the insurance company medical information necessary in the filing of lawful claims by ICCHC, staff or services rendered by them for myself or my dependents.
4. I consent to the release of information for audit purposes to third party payors, prescription assistance programs and government agencies.
5. I hereby authorize payment directly to ICCHC of benefits due to me in my pending claim(s) and/or Major /Medical Benefits otherwise payable to me, not to exceed ICCHC's or the physician's regular charges for this service.
6. I certify that the information given by me in applying for payment under Title XVII of the SSA Act is correct. I authorize any holder of medical or other information intermediaries or carriers or any other insurer any information needed for this or any related Medicare/Medicaid Claims. I request benefits be made on my behalf.
7. I understand the fee policies of ICCHC and my obligations to pay medical expenses under this policy.
8. I agree that this form shall be valid for one (1) year.
9. I agree that a Photostat copy of this form is as valid as the original for the period stated.
10. I understand and agree that dental X-Rays are to remain at ICCHC.
11. I certify that the above is true and accurate to the best of my knowledge and changes in insurance status or income which effects reduced or discounted services including free prescription programs will be reported to ICCHC. I understand that I may be prosecuted if I provide false information and receive discounted benefits.

Patient (Print Name)

Signature

MINOR CONSENT:

I ATTEST THAT I HAVE REVIEWED THE ABOVE AND AM AWARE OF ITS CONTENTS.

Note: If the patient is a minor, the parent, guardian, relative or person temporarily standing in loco parentis, any consent for the minor under his care. Print the name of the minor on the first line. Print and sign the name of parents, guardian, relative or loco parentis on the second line. Address and phone number is also required.

Patient (MINOR)
For Legal Minors:

BY _____
Print Name of Person giving consent

Relationship to Patient

Signature of Person giving consent

Telephone Number

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received the Notice of Privacy Practices from Iberia Comprehensive Community Health Center.

X _____ Date: _____

In lieu of patient signature, I _____, a staff member of Iberia Comprehensive Community Health Center, state that _____ has been given our current Notice of Privacy Practices.

X _____ Date: _____

PATIENT RIGHTS & RESPONSIBILITIES

I have read and fully understand the rights and responsibilities as an ICCHC patient. A copy of this signed document will be placed in your medical record.

Patient Signature

Date

Interviewer's Signature

Date