



OP 4 – 013.000.02

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

## Consent Form

**Consent to Treatment:** I authorize Chota Community Health Services (CCHS) and its medical, nursing and other professional staff members to provide such health care services and administer such diagnostic and therapeutic procedures and treatments as, in the judgement of CCHS’s medical personnel is deemed necessary or advisable in my care. This includes all routine diagnostic tests and procedures, including diagnostic x-rays, the administration and/or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination.

**Assignment of Benefits:** I assign to CCHS all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by CCHS.

**Financial Obligations:** I agree, that, except as may be limited by law or CCHS’s agreements with third party payers, in the event of non-payment by a third party for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at CCHS facilities in accordance with the rates and terms of CCHS in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurances or deductibles.

**Acknowledgement of Receipt of Privacy Practices:** I acknowledge that I have been provided a copy of the Chota Community Health Services (CCHS) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by CCHS and how I may obtain access to and control the use and disclosure of this information.

**I certify that I have read this form and that I am the patient or I am duly authorized by the patient as the patient’s representative to execute this form and accept its terms.**

**Signature of Patient or Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Nature of Relationship to Patient (if patient not signing):** \_\_\_\_\_

8/26/2020