Partnership
Community Health Center

Patient Label

PATIENT CONSENT FORM

□____(Initial) I recognize that I have a health care condition requiring care by a **PARTNERSHIP COMMUNITY HEALTH CENTER** medical, mental, oral or other health care professional and hereby voluntarily consent to the customary examinations, tests and procedures. I recognize that healthcare practice is not an exact science and that diagnosis and treatment may involve risks of injury or death. I acknowledge that no guarantees have been made to me as to the results of examination or treatment.

□____(Initial) I acknowledge that I have received a copy of **PARTNERSHIP COMMUNITY HEALTH CENTER Notice of Privacy Practices.**

□____(Initial) I authorize release of all information required to act on insurance claims and permit a photographic reproduction of this authorization to be used in place of the original assignment. I hereby assume responsibility for all services rendered and assign to **PARTNERSHIP COMMUNITY HEALTH CENTER** the medical benefits and/or surgical benefits I am entitled from my insurance company for services provided.

□____(Initial) I have read this form and information provided and understand the questions and statements. Any questions regarding this form have been explained..

Patient Name: (Print)_____

_____ _____/_____/_____

Signature of Patient or Person Legally Authorized to Sign on Patient's Behalf Date

MEDICARE AUTHORIZATION (IF APPLICABLE)

I request that payment of authorized Medicare benefits be made on my behalf to PARTNERSHIP COMMUNITY HEALTH CENTER for any services furnished to me. I understand that this healthcare provider accepts Medicare assignment and agrees to accept the charge determination for the Medicare carrier as the full charge and I am responsible for co-insurance, deductible and non-covered services. I understand that co-insurance and deductibles are based on Medicare charge determination.

_____ _____/_____/_____

Signature of Patient or Person Legally Authorized to Sign on Patient's Behalf Date