COMMUNITY HEALTH PARTNERS

Conditions of Treatment

1. Medical Consent: I hereby consent to the provisions of health care services, including tests and treatments, such as X-rays, exams, immunizations, administration of drugs, behavioral health consultation, lab tests (including HIV), and other services at Community Health Partners, Inc. (CHP) as directed by my provider. I have the right to discuss all treatments with my provider and to refuse any procedure or treatment.
2. Information Privacy: I acknowledge receipt of the CHP Notice of Privacy Practices. I will refer to the CHP Notice of Privacy Practices regarding the release of my health information.
3. I authorize my health care provider and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to childcare facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.
4. This document does not expire unless revoked by the patient. Patients have the right to revoke their consent to treatment or release of information by stating this expectation to staff in writing.
5. Insurance Disclosure: I understand that it is my responsibility to notify my insurance company directly within the time limits of my policy if I am treated at CHP or for pre-authorization of special procedures and/or tests. CHP may submit a separate charge for behavioral health consultation services provided as part of your medical visit.
6. Financial Agreement: I hereby assume full responsibility for charges I incur for services provided by CHP and I agree to pay said charges in full. I have given my insurance information, if any, to CHP. I hereby authorize CHP to bill my insurance carrier on my behalf. I also authorize my insurance carrier to make payments of any benefits I may be entitled to directly to CHP for services rendered. It is my understanding that I will be responsible for any balance not paid by this insurance. If I, or my guarantor, choose not to bill my insurance, I will notify CHP of this at the time of my visit and my visit will be considered self-pay. If I am unable to pay in full, I will contact CHPs Billing Department at (406) 832-6304 to discuss a payment plan to make monthly payments on my account. It is further understood that if I do not pay my account in full or make regular monthly payments on my account, my account may be referred to a collection agency. _____ (Guarantor Initials)
7. Personal Valuables: I understand that CHP shall not be liable for personal items left in our facilities.
8. Teaching Purposes: CHP is a clinical training site. I understand that care may be provided to me by students performing under the supervision of CHP medical staff.
9. All Community Health Partners sites are smoke free. Thank you for not smoking.

I certify that I have read the above information and as the patient, or one who is duly authorized to act in a representative capacity for the patient, that the information has been fully explained, that I understand its content, that it may not be modified and that I may withdraw my consent for services at any time.

Patient Full Name: _____ Date of Birth: _____

Patient/Guarantor Signature: _____ Date: _____

Relationship to Patient: _____

Reason Patient Unable to Sign: _____

Email: _____

OFFICE USE ONLY: Witness: _____ Time: _____ Date: _____	SCAN: Registration/Documents Table CHP Consent to Treatment

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