Eagle Valley Medical Center

Patient Name: _____ Date of Birth: _____

Consent to Treat
I (the patient) voluntarily consent to such clinical care involving medical evaluation, diagnostic procedures, and medical treatment as may be ordered by my provider or consulting physicians, their assistants or their designees. I understand that the services provided for the undersigned patient are under the control and direction of my physician. I also am aware that the practice of medicine and surgery is not an exact science and agree to hold practice/physician harmless. I acknowledge that no guarantees have been made concerning the result of any treatment or examination to be rendered. I authorize this facility and its designees to dispose of and/or preserve for medical diagnostic purposes any tissue removed during any procedure.

Release of Information
I authorize Eagle Valley Medical Center and its designees to release such patient and guarantor information from the patient's medical or financial records, as many as may be necessary, for the processing of insurance claims; for advance, concurrent, or retrospective review of services; for receipt of benefits; or for continuity of health care. The information may be released to third party payors and their agents and/or health care providers involved in care rendered in the clinic or in continuing care. I also understand that such information may be released as permitted or required by law.

Health Information Exchange
Eagle Valley Medical Center participates in Quality Health Network, a regional health information exchange. This is a centralized electronic database which contains personal health information from a variety of health care service providers including hospitals, physician offices, health insurance companies and pharmacies. All network members are subject to HIPAA Privacy laws. By participating in this network, Eagle Valley Medical Center intends to provide timely information to those health care and related service providers who may be involved in your care.

Pharmaceutical History
I authorize Eagle Valley Medical Center and its designees to view my pharmaceutical history from external sources.

Financial Responsibility
The undersigned agrees to assist in the processing of claims for benefits and understands that he/she is totally responsible for payment of all clinical charges for services rendered, regardless of insurance coverage or responsible parties. The undersigned understands that they are responsible for the prompt payment of any portion not covered by insurance including coinsurance, deductibles, and copays and may be responsible for non-covered services and claims denied by your insurance. The undersigned acknowledges that the payment of copays is expected at the time of service as well as any outstanding balances.

- Possible Additional Charges: Lab and diagnostic testing/procedures, x-rays, and radiologist fees.

Minor Consent: I authorize the following people to consent for evaluation and treatment of the patient named on this record,
August 13-17, 2018 Rainbow Trail/VBS Day Camp
Pastor Sid Spain, United Methodist Church of Eagle Valley Cynthia Sibley, Rainbow Trail volunteer staff
Pastor Scott Beebe, Mt of the Holy Cross Lutheran Church
Jeanine Kenney, Rainbow Trail Day Camp Director
Louise Carter, UMC of Eagle Valley
Are there any custodial issues that impact authorization for medical care? Yes____ No____

If yes, Explain_____

I authorize the minor on this record to present for evaluation and treatment, without being accompanied by a parent and/or guardian

Authorized Signature _____

I have read and understand and have been given the opportunity to receive a copy of the forgoing terms, conditions, authorizations and consents and have been given the opportunity to ask any questions.

I understand that the provision of health care services is not an exact science and acknowledge that no guarantees have been or can be made to me regarding the results of any examination or treatment that may be rendered to me during my clinic visit.

I certify that I am authorized to execute this document on the patient's behalf, and I accept the conditions of service contained herein.

_____ _____
Patient/Authorized Signature **Date**

_____
Relationship to Patient