Acknowledgment of Privacy Notice and Conditions of Treatment

I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices for Floyd Valley Healthcare and Floyd Valley Clinics. The Notice of Privacy Practices is in the privacy brochure that can be found in the waiting area and on our website at www.floydvalleyclinics.org. Floyd Valley Healthcare reserves the right to modify the privacy practices outlined in the notice.

_____ _____

Patient Legal Name (Please Print) Parent/Guardian Name (if patient is a minor)

_____ _____

Patient Date of Birth Primary Phone Number/Cell Phone Number

Please list the names and relationship of family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and healthcare operations):

_____

Name/Relationship/Phone #

_____

Name/Relationship/Phone #

_____

Name/Relationship/Phone #

_____

Name/Relationship/Phone #

_____(please initial) **FOR FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS**

I understand that I am financially responsible to pay FVH Floyd Valley Clinics its usual charges for all services received, including any balances such as co-pays, deductibles, non-covered services, co-insurances and items not covered by my insurance company. FVH Floyd Valley Clinics will assist in receiving reimbursement as much as possible; however, you are responsible for your bill. Should it be necessary to take legal action on this account, you will be responsible for the balance plus interest, as well as court costs and fees.

_____(please initial) **RECORDS RELEASE FOR CLAIMS PAYMENT**

I authorize direct payment of medical/surgical benefits to FVH Floyd Valley Clinics for the services rendered to me. I authorize the release of medical record information to any insurance company that may be necessary for verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization. My signature below represents that I have read and understand the terms above. This authorization shall remain in effect unless revoked by me in writing, and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this notice is as valid as the original.

_____(please initial) **CONSENT TO TREAT**

I, the undersigned, hereby voluntarily authorize the attending healthcare provider and/or his/her assistant, FVH Floyd Valley Clinics and its employees to administer any x-ray examination, laboratory studies, medical or minor surgical diagnosis, treatment and service that are deemed advisable. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me about the curative value of such examination, or treatment on my condition.

_____ _____

Patient Signature Date

_____

Parent or Guardian Signature (if patient is a minor)