Consent for Treatment and Insurance Billing

Please Read and Sign Below.

I give consent for treatment by Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for medical, dental and/or mental health services. I understand that services are available, regardless of ability to pay and without discrimination. If I am consenting for a minor child, I understand that no treatment will be given without my knowledge or consent unless the treatment relates to an emergency or the treatment is otherwise permitted under applicable federal or state law.

- I understand that if I am consenting to treatment of my child, if a court order has been entered with respect to the conservatorship of said child, or impacting my rights to consent to the child's care and treatment, CHC/SEK will not render services to the child until CHC/SEK has received and reviewed the most recent court order.

- I understand that the information in my health record (if a mature minor) or my child's health record is confidential and will not be released to any unauthorized person or agency without consent.

- I assign to CHC/SEK any and all benefits payable from any insurance provider covering the patient or person responsible for the patient's care to be paid directly to CHC/SEK which will be applied to the charges for services rendered.

- I understand that vision and hearing screenings may be billed to my insurance carrier.

- I understand that CHC/SEK may disclose all or any part of the patient's medical record to any insurance company, corporation or person which is or may be liable under a contract or part of CHC/SEK's charges, including, but not limited to, medical services companies, insurance companies or pharmaceutical manufacturers.

- I authorize CHC/SEK to disclose all or any portion of my health record (if a mature minor) or my child's health record to my health care provider (if a mature minor) or my child's health care provider who is: _____.

- I authorize CHC/SEK to disclose all or any portion of my health record (if a mature minor) or my child's health record to school personnel as it relates to my child's academic success.

- I authorize CHC/SEK to examine my school records (if a mature minor) or my child's school records to assist staff in providing the necessary care for my child.

- If there are services you would like to opt out of, please list them here: _____.

With my signature, I certify that I understand the above and that I am authorized to sign for the patient.

_____
Signature of Patient, Agent, Representative, Parent, Legal Guardian or Responsible Party

_____ _____/_____/_____
Relationship to Patient Date (Month/Day/Year)

Printed Student Name: _____ Student Date of Birth: _____/_____/_____

Form Updated: 01/2021