CONSENT FOR TREATMENT AND INSURANCE BILLING

Please Read and Sign Below.

I give consent for treatment by the Community Health Center of Southeast Kansas for medical, dental and/or mental health services. I understand that services are available without discrimination prohibited by federal and state law. If consenting for a minor child, I understand that no treatment will be given without my knowledge or consent unless it is an emergency.

- I understand that the information in my (if a mature minor) or my child's medical 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 (if a mature minor) or my child's health record to my (if a mature minor) or my child's medical provider who is ________________________________.
- I authorize CHC/SEK to disclose all or any portion of my (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 (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:

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

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

________________________________ ________________________________
Relationship to Patient Date

Printed Student Name:______________________________ Student Date of Birth: ________________

4/2018