OUTREACH HEALTH SERVICES, INC

GENERAL CONSENT FORM

Authorization for Diagnosis and Treatment

_____ (initial) I hereby consent to the medical, dental, or optical examination, treatment, and procedures which may be performed during the office visits, including but not limited to lab works, x-rays, exams, injections, immunizations, dental fillings, extractions and anesthesia, local or general, as may be ordained advisable or necessary by the attending physician, advanced registered nurse practitioner, physician assistant, dentist and optometrist of Outreach Health Services, Inc. (OHS) or by their consulting physicians, dentists, and optometrists.

Assignments of Benefits

_____ (initial) I hereby give permission to OHS to release any medical information to Medicare, Medicaid, or the insurance company that is needed to receive payment for medical, dental, or optical services rendered to me or other persons listed on the patient registration form.

Notice of Privacy Practices

_____ (initial) I acknowledge that I have reviewed OHS's Notice of Privacy Practices, which describes how medial information about me may be used and disclosed and how I can get access to this information. I may obtain a copy of Patient's Bill of Rights and Responsibilities upon request.

Financial Agreement

Your care at OHS is a partnership between you and the staff at OHS. We rely on the fees paid by you and your insurance company to keep the clinics operating. We are not responsible for any charges by hospitals, other physicians, or any other services outside OHS.

For Patients with No Insurance

_____ (initial) I agree to apply for Sliding Fee Discount as recommended by OHS staff. I understand that failure to provide proof of income and complete the process will result in my being responsible for 100% of charges. I agree that I will pay all charges for which I am responsible at the time of services or make payment arrangements with the Collection Department. I understand that if I fail to pay my bill, OHS reserves the right to limit services to me.

For Patients with Insurance

_____ (initial) I understand that OHS will bill my insurance company. I agree to show current insurance information at each visit and notify OHS with any charges in coverage. I agree to pay my co-payment and required deductible at the time of service and to pay for services not covered by my insurance plan. I will contact my insurance, if necessary, to ensure payment for services that I have received.

I agree that I have read and understand the above consent and will accept its terms.

Signature of Patient/Parent/Guardian:_____ **Date** _____

Signature of Witness: _____ **Date** _____