# JEFFERSON COMPREHENSIVE HEALTH CENTER, 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 work, 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 Jefferson Comprehensive Health Center, Inc. (JCHC) or by their consulting physicians, dentists and optometrists.

## Assignment of Benefits

_____ (initial) I hereby give permission to JCHC 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 JCHC's Notice of Privacy Practices, which describes how Medical information about me may be used and disclosed and how I can get access to this information. I may obtain a copy of the Notice of Privacy Practices upon request.

## Patient's Bill of Rights and Responsibilities

_____ (initial) I acknowledge that I have reviewed and agreed with JCHC Patient's Bill of Rights and Responsibilities. I may obtain a copy of Patient's Bill of Rights and Responsibilities upon request.

## Financial Agreement

Your care at JCHC is a partnership between you and the staff of JCHC. 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 JCHC.

**For Patient with No Insurance**:

_____ (initial) I agree to apply for Sliding Fee Discount as recommended by JCHC 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 service or make payment arrangements with the Collection Department. I understand that if I fail to pay my bill, JCHC reserves the right to limit services to me.

**For Patient with Insurance**:

_____ (initial) I understand that JCHC will bill my insurance company. I agree to show current insurance information at each visit and notify JCHC with any changes 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.

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

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

**Signature of Staff Witness:**_____ **DATE** _____