PARK
CLINIC

ACKNOWLEDGEMENTS AND CONSENT

CONSENT FOR TREATMENT

By signing this consent, I am authorizing the provider to perform and/or order another person to perform all exams, tests, procedures and any other deemed necessary or advisable for the diagnosis and treatment of my medical condition(s).

PHOTOGRAPHY, VIDEO/AUDIO MONITORING/RECORDING ACKNOWLEDGMENT

I authorize photography, video/audio monitoring/recording may be taken for patient care, security or for the purposes of health care operations.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Electra Hospital District Notice of Privacy Practices which describes how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

I have reviewed the Patient Rights and Responsibilities document. I understand that I am entitled to receive a copy of this document upon request.

ASSIGNMENT OF INSURANCE BENEFITS

I assign to the Clinic and/or provider all payments for medical services rendered to myself and/or dependents. I authorize my insurance carrier(s) to directly pay the Clinic and/or provider for any benefits payable for said care and/or treatment. I agree to be responsible for any portion of the bill not paid by my insurance carrier unless contractual agreements have been made which negates responsibility.

Patient Name (printed)	Date of Birth
Patient / Guarantor Signature	Date