CLINCH RIVER HEALTH SERVICES, INC.
GENERAL CONSENT FORM

NAME: _____ DOB: _____ SSN: _____

1. **CONSENT TO FILE INSURANCE/CORRECT INFORMATION**
   I authorize the release of any and all medical information necessary to process my insurance claims. I permit a copy of the authorization to be used in place of the original. I authorize Clinch River Health Services to file my insurance for services rendered. I request that payment be made directly to Clinch River Health Services, Inc.. I certify that the information that I have reported with regard to my insurance coverage and my personal information is correct. I understand that I am responsible for any and all balances that my insurance company does not pay. I understand that claims may be filed electronically through a safety net internet portal. **INITIALS:** _____

2. **HIPPA NOTICE OF PRIVACY POLICY**
   I acknowledge that I have received and or have read Clinch River Health Services' HIPPA Notice of Privacy Policy.
   INITIALS: _____

3. **CONSENT FOR TREATMENT**
   I, _____, give my consent to the medical staff of Clinch River Health Services, Inc. to perform emergency medical treatment, acute or chronic medical treatment, preventive health care, behavioral/mental health care, and health maintenance care as deemed medically necessary. **INITIALS:** _____

   (If the above named individual is a minor at the time of consent, a parent or legal guardian must sign this consent for treatment.)

   PARENT/GUARDIAN: _____ **RELATIONSHIP:** _____

4. Clinch River Health Services, Inc. is serious about the responsibility of keeping your medical and account information private and confidential. In order for us to share any of your information with someone else, you must designate who you want to have access to this information and give us your signed permission to share the information.

   A. If we are unable to get in touch with you or someone calls the office about you, please list family members or others we may notify concerning your general medical condition, lab results, test results, other treatment results, or appointment information. If you do not list anyone, then we will not share your private information with anyone else

   NAME: _____ **RELATIONSHIP:** _____ **PHONE #:** _____ **DATE:** _____

   NAME: _____ **RELATIONSHIP:** _____ **PHONE #:** _____ **DATE:** _____

   B. If you wish to designate someone else to receive information concerning your account and balance information, please list below.

   NAME: _____ **RELATIONSHIP:** _____ **PHONE#:** _____ **DATE:** _____

   NAME: _____ **RELATIONSHIP:** _____ **PHONE #:** _____ **DATE:** _____

   C. If we are unable to contact you and you have an answering machine, do we have your permission to leave a message?

   YES: _____ **NO:** _____

PATIENT'S SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____
(If patient is a minor.)

WITNESS SIGNATURE: _____ **DATE:** _____

(THIS CONSENT FORM WILL BE USED AS NEEDED. YOU MAY REVOKE OR CHANGE ANY OF THE ABOVE CONSENTS AT ANYTIME.)