LOGAN HEALTH

Conrad

Logan Health Rural Health Clinic - Conrad
809 SUNSET BLVD
PO BOX 668
CONRAD, MT 59425
(406) 271-3231 Phone

CONSENT TO TREAT

Patient Name: _____ **DOB:** _____

ACCOUNT : _____ **DOS:** _____ **Admit Time:** _____ **Svc Code:** _____

CONSENT

I consent to the service that may be provided from Logan Health Rural Health Clinic - Conrad which may include, but are not limited to, nursing care and other medical services provided to me upon the instructions of my provider. If I should leave prior to completion of any service or treatment, I release said provider(s), staff and/or Logan Health Rural Health Clinic - Conrad of all responsibility of any and all adverse effects. I acknowledge that no guarantees have been made regarding the outcome of care. In cases of emergency, consent shall be implied.

DISCLAIMER

I recognize that all practitioners furnishing services may not be employees or agents of Logan Health Rural Health Clinic - Conrad, i.e. Telehealth, and I may receive bills from those practitioners as well.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

I understand I am financially responsible for payment to Logan Health Rural Health Clinic - Conrad for services rendered to myself and/or dependent(s) regardless of the existence of insurance for such services. I understand payment for services is expected at the time of service and in accordance with Logan Health - Conrad's Billing and Collection Policy. Should this account become delinquent and be referred to an outside collection agency, I agree to pay all collection expenses, court costs, interest, and reasonable attorney fees. I authorize Logan Health Rural Health Clinic - Conrad or asignee to contact me by regular mail, by email or by telephone (including cell phone) regarding any matter related to my account. I authorize monies paid to Logan Health Rural Health Clinic - Conrad by or on behalf of the patient and otherwise refundable to the patient/guarantor to be transferred to other accounts at this facility or any other Logan Health - Conrad entity for which the patient/guarantor has financial responsibility. In the event a third party may be liable for payment of services, I acknowledge Logan Health Rural Health Clinic - Conrad may submit a medical lien as defined in MCA 71-3-114 to the third party for recovery of payment. I herby assign and authorize all medical payments and benefits otherwise payable to me for services rendered at Logan Health Rural Health Clinic - Conrad to Logan Health Rural Health Clinic - Conrad. I further authorize release of all information necessary to secure payment of benefits.

INSURANCE DISCLAIMER

I understand it is my responsibility to know and follow the guidelines/requirements set forth by my insurance policy. I understand my insurance policy may require prior authorization before services are rendered and it is my responsibility to obtain prior authorization. I understand I am financially responsible for any charges not covered by my insurance benefit plan.

MEDICAIDE PRIVATE PAY AGREEMENT

If I am a beneficiary of Montana Medicaid insurance and my coverage is inactive for today's date of service; I understand I am financially responsible for all charges.

RELEASE OF INFORMATION

I grant Logan Health - Conrad and their providers and independent separate entities providing services to me through Logan Health - Conrad, to release medical and account information necessary for the adjudication of all claims, treatment, and other necessary or desired healthcare referrals. This information shall be released in accordance with the Health Insurance Portability and Accountability Act.

PERSONAL VALUABLES

Logan Health Rural Health Clinic - Conrad shall not be liable for the loss or damage to any money, valuables, other article of unusual value, or any other personal property.

I verify that the information provided at registration is accurate, I have read and understand all statements and have had the opportunity to ask questions and have those questions answered. I certify that I am the patient or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature of patient or responsible party: _____ Date/Time: _____

Staff Signature: _____ Date/Time: _____