Conditions of Treatment

1. Medical Consent: I hereby consent to the provisions of health care services, including tests and treatments, such as exams, immunizations, administration of drugs, behavioral health consultation, lab tests (including HIV), and other services at Community Health Partners, Inc. (CHP) as directed by a medical provider. I have the right to discuss all treatments with my provider and to refuse any procedure or treatment.
2. Information Privacy: I acknowledge receipt of the CHP Notice of Privacy Practices. I will refer to the CHP Notice of Privacy Practices regarding the release of my health information.
3. Insurance Disclosure: I understand that it is my responsibility to notify my insurance company directly within the time limits of my policy if I am treated at CHP or for pre-authorization of special procedures and/or tests. CHP may submit a separate charge for behavioral health consultation services provided as part of your medical visit.
4. Financial Agreement: I hereby assume full responsibility for charges I incur for services provided by CHP and I agree to pay said charges in full. I have given my insurance information, if any, to CHP. I hereby authorize CHP to bill my insurance carrier on my behalf. I also authorize my insurance carrier to make payments of any benefits I may be entitled to directly to CHP for services rendered. It is my understanding that I will be responsible for any balance not paid by this insurance. If I, or my guarantor, choose not to bill my insurance, I will notify CHP of this at the time of my visit and my visit will be considered self-pay. If I am unable to pay in full, I will contact **CHPs Billing Department at (406) 832-6304** to discuss a payment plan to make monthly payments on my account. It is further understood that if I do not pay my account in full or make regular monthly payments on my account, my account may be referred to a collection agency. _____ (Guarantor Initials)
5. Personal Valuables: I understand that CHP shall not be liable for personal items left in our facilities.
6. Teaching Purposes: CHP is a clinical training site. I understand that care may be provided to me by students performing under the supervision of CHP medical staff.
7. Behavioral Partnership: The greatest success in providing and receiving health care comes when there is a partnership based on mutual respect between patient and health care provider. As patient and health care provider, we respect each other's rights and accept our individual responsibilities. I understand that I have the following responsibilities: I will treat the staff and other patients at the clinic politely and with respect, I will keep my scheduled appointments and call the clinic to cancel an appointment if I cannot make it, and I will not use inappropriate language or yell at anyone in the clinic or over the phone. All Community Health Partners sites are smoke free. Thank you for not smoking.
8. This document does not expire unless revoked by the patient. Patients have the right to revoke their consent to treatment or release of information by stating this expectation to staff in writing.

I certify that I have read the above information and as the patient, or one who is duly authorized to act in a representative capacity for the patient, that the information has been fully explained, that I understand its content, that it may not be modified and that I may withdraw my consent for services at any time.

Patient/Guarantor Signature: _____ Date: _____

Relationship to Patient: _____

Reason Patient Unable to Sign: _____

Witness: _____ Time: _____ Date: _____

SCAN: Registration/Documents Table
CHP Consent to Treatment