# CONSENT TO TREATMENT

**Name of Patient:** _____

☐ I hereby voluntarily consent for **MEDICAL SERVICES** on behalf of (**CHECK ONE**) □ myself □ a minor for whom I am legally responsible (the "Patient") to outpatient care from Boston Mountain Rural Health Center, Inc. ("Boston Mountain"), including: examination, diagnosis, medical treatment and behavioral health services. I further consent to the performance of medically necessary diagnostic procedures, examinations, and medical treatment by Boston Mountain's medical personnel. I understand that this consent remains in effect so long as the Patient is a patient of Boston Mountain.

☐ I hereby voluntarily consent **DENTAL SERVICES** on behalf of (**CHECK ONE**) □ myself □ a minor for whom I am legally responsible (the "Patient") to receive dental treatment deemed necessary by the providers at Boston Mountain. These procedures include but are not limited to; examinations, prophylaxis (cleanings), fluoride treatments, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. I understand that this consent remains in effect so long as the Patient is a patient of Boston Mountain.

**Authorization to Release Information**
I hereby authorize Boston Mountain to release any necessary information acquired in the course of the Patient's examination or treatment to any authorized agent related to treatment, payment, or healthcare operations.

**Acknowledgement**
I acknowledge that I am responsible for the payment of the Patient's account balance.

**Notification of Privacy**
I have received a copy, read, and understand the Boston Mountain Notice of Privacy Practices.

**Authorization to Access Medical Records**
I hereby authorize Boston Mountain to access the Patient's medical records and protected health information.

□ (**CHECK IF APPLICABLE**) I authorize the following individual(s) to consent to and authorize medical treatment for the Patient:

_____
Full Name Relationship to Patient Telephone Number

_____
Full Name Relationship to Patient Telephone Number

**Authorization to Pay Benefits to Boston Mountain**

(**CHECK ONE**)

□ Private Insurance

I authorize Boston Mountain to file insurance and third party payor claims for services rendered to the Patient. I understand that insurance is filed as a courtesy and that I am responsible for payment of all services within ninety (90) days. I also authorize the release of all necessary medical information as needed for reimbursement from my insurers. I authorize payment of medical benefits by any insurance, whether to Boston Mountain or myself.

□ Medicare Insurance

I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information related to services provided to the Patient and reimbursed by Medicare. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify Boston Mountain of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 3801-3812 provides penalties for withholding information). Regulations pertaining to Medicare assignment of benefits may apply.

□ Medi-Gap

I authorize any holder of medical or other information about me to release to Boston Mountain any information related to services provided to the Patient that is subject to "Medi-Gap" coverage. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand that Boston Mountain may not accept assignments on all Medi-Gap claims. I agree to be responsible all amounts not covered by Medi-Gap coverage.

I understand and agree to this form on behalf of the Patient.

_____ _____ _____
Name Relationship to Patient (if not you) Signature Date