Community Health Center of the Black Hills
Consent for Treatment

I request that Community Health Center of the Black Hills provide me and/or my family with medical care. I acknowledge my responsibility to pay for that care according to the category assigned. I also understand that if I have private insurance or Medicaid, I may still have to pay part of the fee. I authorize payment of medical benefits to Community Health Center of the Black Hills for services described.

Patient Financial Policy and Payment Responsibility
Payment is expected in full when services are rendered. The following is our Patient Financial Policy: Regarding Medicaid and/or Medicare: Please provide us with your current Medicaid and/or Medicare card at each visit. If you have a share of cost, you will be asked to pay that amount at the time of service. Private Insurance: Please provide us with a copy of your insurance card at each visit. if payment from the Insurance company is not received by 120 days, I am responsible for charges. All co-pays and deductibles are due at the time of service. Private Pay Patients: Full payment is due at the time of service. We accept CASH, CHECK, and VISA/MASTERCARD (credit or debit cards). We offer a CHCBH Discount Program if you qualify. Please ask a receptionist for additional information. All CHCBH Discount Program co-pays are expected at the time of service. I realize that I am responsible for any and all differences in charges and payments. I understand that I may be eligible for the CHCBH Discount Program but unless I bring proof of income (within 10 business days of application), I am responsible for the entire bill. I understand that it is my responsibility to inform the staff of CHCBH of any changes in my income, family status, or insurance status. I understand that it is my responsibility to update financial paperwork on a yearly basis. I am aware that if I choose to have my account be Confidential, I am responsible for any balances that my account accumulates, and I have the understanding that I will not be receiving any statements or phone calls due to this Confidential status. I further understand that providing CHCBH with false information will result in immediate recalculation of the sliding fee scale for those patient fees occurring during the fraudulent periods and all fees will be due and payable immediately. Thank you for choosing us as your health care provider. Please let us know if you have questions or concerns. By signing below, you acknowledge and accept our Patient Financial Policy.

Acknowledgement of Receipt of Notice of Privacy Practices and Patient Rights/Responsibilities
In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health Information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The NOTICE OF PRIVACY PRACTICES you have been given describes these uses and disclosures in detail. The PATIENT RIGHTS AND RESPONSIBILITIES informs you of your rights and responsibilities as a CHCBH patient. I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES and PATIENT RIGHTS AND RESPONSIBILITIES forms from the Community Health Center of the Black Hills.

Signature: ______________________________________ Date: ____________________________
If signing as a personal representative of the patient, describe the relationship to the patient:
Signed by: _____________________________________ Relationship: ______________________