White Bird Medical Clinic

1400 Mill Street Eugene, Oregon 97401 541.484.4800

NAME: ______________________________ **Date of Birth:** __________________

CONSENT TO TREATMENT

By signing below, I, (or my authorized representative on my behalf) authorize White Bird Medical Clinic and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

____

SIGNATURE TODAY'S DATE

____

SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE

ACKNOWLEDGEMENT AND CONSENT

I understand and agree that White Bird Medical Clinic may use and disclose my health information in the manner described in White Bird Medical Clinic's *Notice of Privacy Practices*. By signing below, I agree that I have reviewed and understand the information included in the *Notice of Privacy Practices* and have been given the option to receive a printed copy of that notice.

____

SIGNATURE TODAY'S DATE

____

SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE

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PERMISSION TO BILL INSURANCE

In order for White Bird Medical Clinic to process your insurance claims, we will need your signature to release payment. I authorize release of any information relating to any claim for services rendered to me or my dependents. I assign and request your company to pay directly to White Bird Medical Clinic insurance benefits otherwise payable to me or my dependents. I understand I am financially responsible to White Bird Medical Clinic for charges not covered by this assignment.

SIGNATURE TODAY'S DATE

SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE

PERMISSION TO COORDINATE CARE

I understand and agree that White Bird Medical Clinic may use and disclose my health information to other White Bird Clinic programs as well as to other service organizations for the purpose of coordinating care with those entities. Additionally, this information can also include (check all that apply):

☐ HIV/AIDS info ☐ Mental Health info ☐ Genetic Testing info ☐ Drug/Alcohol diagnosis, treatment, or referral info

SIGNATURE TODAY'S DATE

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PATIENT RIGHTS AND RESPONSIBILITIES

I have read and understand my rights and responsibilities as a patient of this practice (White Bird Medical Clinic - *Patient Rights and Responsibilities)* I understand that it is imperative that I meet these responsibilities in order to remain a patient at this practice.

☐ Yes! I have read and understand my rights and responsibilities as a patient of this practice.

SIGNATURE TODAY'S DATE

SIGNATURE (PARENT OR GUARDIAN) TODAY'S DATE