Banyan Community Health Center, Inc.

General Consent for Treatment

1. I, the undersigned or legal guardian, grant permission for myself and family to undergo all necessary tests, treatments, and other procedures required in the course of study, diagnosis, and treatment of illness by medical staff of Banyan Community Health Center (BCHC).

2. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment and examination by Banyan Community Health Center, Inc.

3. I consent to the release of medical information to other agencies accepting the patient for medical referral, or institutional care, and consent to the release of medical information to the patient's insurer and give permission to release data (both medical and personal) to such governmental agencies as is required by BCHC by- laws, rules, regulations, or by contract.

4. I consent to the release of medical and financial information for auditing purposes.

5. I hereby authorize payment directly to BCHC of benefits due to me in my pending claims and/or other insurance benefits otherwise payable to me, but not to exceed the BCHC and/ or Physician's regular charges for this period of treatment. I agree that a copy of this authorization is as valid as the original. I understand that if my insurance does not approve the charges for this visit, I am fully responsible to Banyan Community Health Center for payment.

6. MEDICARE PATIENTS ONLY: I authorize any holder of medical or other information about me to release to centers for Medicare and Medicaid (CMS) or its intermediaries or carriers, any information needed for this or any subsequent Medicare claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party that accepts assignment for such claim.

7. BY SIGNING THIS DOCUMENT, I ATTEST THAT ALL INFORMATION IS TRUE AND CORRECT AND I WILL NOTIFY BANYAN COMMUNITY HEALTH CENTER OF ANY CHANGES TO MY INSURANCE, INCOME OR CONTACT INFORMATION, AND THAT THIS CONSENT WAS GIVEN IN MY PREFERRED LANGUAGE.

Signature: _____ **Date:** _____

Guardian Name: _____ **Witness:** _____