Morthland College Health Services
309 W St Louis St., Suite C
West Frankfort, IL 62896

CONSENT FOR SERVICES

Consent for Routine or Emergency Treatment: I hereby consent to and authorize the attending physician, referral physician, or their assistants and designees of Morthland College Health Services to perform such examinations, treatments, invasive procedures, and to administer any medications which is his/her opinion may be deemed necessary or advisable. This consent also includes all routine diagnostic radiologic procedures including the administration of radiographic contrast media and radionuclides.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations in the hospital and/or clinic.

In order to assure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or any referring provider.

I agree to the release of medical/social information to agencies that may be deemed necessary as advised by my physician or a Morthland College Health Services representative for the purpose of continuity of care.

Release of Personal Property Responsibility: I understand that Morthland College Health Services is not responsible for the loss of valuables such as teeth, glasses, clothing, jewelry medications, or other articles of value.

Release of Medical Records: I understand that I may review and copy my medical records at my own expense and that tis review will take place in the clinic during regular business hours. I also understand that I may authorize other persons to review and copy my medical record by signing a statement which identifies the person, the purpose of this disclosure, the type of information to be disclosed and the time period which disclosure to the person is permitted.

Guarantee of Account/responsibility for Payments: For and in consideration of services rendered and to be rendered by Morthland College Health Services, I hereby guarantee payment of all charges incurred or services rendered. I understand that I am financially responsible for services that are deemed non coverable and for any balances, such as deductible and coinsurance, as determined by my insurance carrier. I understand that Morthland College Health Services requires copays and self pay charges to be paid at the time of services. I further agree to pay all attorney fees and court costs incurred by Morthland College Health Services in the collection of amounts for which I am responsible.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state laws, and outlining my rights regarding my health information.

I certify that I have read, understand, and agree to the above.

_____ _____

Signature of Patient or Authorized Person Date

_____ _____

Signature of Witness Date

_____ _____

PRINTED name of Patient Date of Birth