NORTON SOUND
HEALTH CORPORATION

Patient Identification:

Name: _____ Birthdate: _____ Phone: _____

Mailing Address: _____ Language of Choice: _____

How many times have you been seen for this problem? _____

Are you currently insured? YES, with whom? _____No___
Is this visit work related? No Yes

Patient Consent

CONSENT TO TREATMENT: I give consent to receive routine medical treatment by healthcare professional at Norton Sound Health Corporation (NSHC). I understand that I have a right to participate in the decisions regarding my health care. I also understand that, except in emergency or other unusual circumstances, no medical treatment shall be performed until the physician or other health care professional discusses with me, the treatment, common risk, and reasonable alternatives for treatment. I further understand that I have the right to refuse any proposed procedure or treatment. I understand that there are no guaranteed results or cures that may be obtained from any examination or treatment I have received. I understand that pictures may be taken and retained by NSHC during the course of my treatment.

CONSENT TO RELEASE MEDICAL INFORMATION: I authorize Norton Sound Health Corporation and its medical providers to release any necessary information regarding this visit from my NSHC medical records, as it may be necessary for coordination of care, or the completions of claims/payments of the bill. I request that any payment from my insurance company(ies) or medical program be made direction to Norton Sound Health Information. I understand that I may revoke this consent in writing at any time, except to the extent action has been taken in reliance on the authorization by NSHC. The undersigned agrees to assume the obligation to pay for the account of the NSHC in accord with regular rates and terms for NSHC for services rendered to the patient.

Have you received a copy of the Notice of Privacy Practice? Yes Refused

_____ _____ _____

Signature of Patient, Parent or Guardian **Relationship to Patient (if applicable** **Date**

NSHC USE: IF PATIENT REFUSES NOTICE OF PRIVACY PRACTICE

Describe good faith effort to obtain acknowledgement that patient received Notice of Privacy Practice and why it was not obtained.: _____

_____

_____

Employee Signature & Date**:** _____