Heartland Family First Medical Clinic

Patient Agreement

1. **CONSENT TO TREAT.** I hereby authorize Heartland Family First Medical Clinic and its employees and agents to examine me/the patient named below and to furnish diagnostic and therapeutic services as they deem necessary and appropriate.

2. **CONSENT ON BEHALF OF ANOTHER PATIENT.** If I am authorizing on behalf of someone other than myself (a child, or an individual with whom you are guardian/Power of Attorney) I give consent to any and all medical care and attention deemed necessary and appropriate by the medical personnel in this office that are licensed by the state of Nebraska. This consent includes but is not limited to, examinations, surgical procedures, treatment, injections, obtaining laboratory testing or x-rays to make a diagnosis, and prescribing medication. This delegation of consent shall be valid until I withdraw delegation of consent.

List any other adult(s) you authorize to present the patient for care at Heartland Family First Medical Clinic

Name	***Relationship to Patient***

3. **FINANCIAL RESPONSIBILITY.** I have been offered the information regarding the financial responsibility and agree to the terms and conditions set forth in the Financial Policy. I understand that I am responsible for and agree to pay all charges regardless of insurance coverage or pendency of claims. I authorize the release of all medical information necessary to process my health insurance claim and request payment of benefits be made to Heartland Family First Medical Clinic. A photocopy of this agreement shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

I acknowledge I have read, understand, and agree to the information set forth above, and I certify that if I am not the Patient, I am legally authorized to sign for the Patient.

Patient Name:_____ **Date of Birth:**____/_____/_____

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Patient Name:_____ **Date of Birth:**____/_____/_____

Patient Name:_____ **Date of Birth:**____/_____/_____

_____

Signature of Patient/Parent/Responsible Party Relationship to Patient

_____/_____/_____

Witness