health services LYON MARTIN
A PROGRAM OF HEALTHRIGHT 360

Patient Consent Form

All Patients: PLEASE READ AND SIGN AT #1 & #2 PRIOR TO FIRST VISIT

1) CONSENT FOR TREATMENT

I,_____**(please print name)** am voluntarily seeking medical care and treatment from Lyon-Martin Health Services (LMHS), a program of HealthRIGHT 360 (HR360), give permission to the medical and mental health staff of LMHS to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations and recommendations they provide me.

_____ ____/____/____

Patient Signature Date

_____ _____

Translator's Name, if applicable Translator's Signature, if applicable

2) CONSENT TO BILL

- If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with HealthRIGHT360 billing policy;
- If my insurance is accepted, I authorize payment of benefits to HealthRIGHT360 or will reimburse HealthRIGHT360 if I am paid directly by my carrier;
- I hereby authorize that HealthRIGHT360 may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy;
- I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory;
- I understand that my insurance may not cover all charges deemed medically necessary by LMHS;
- I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

_____ ____/____/____

Patient Signature Date

_____ _____

Translator's Name, if applicable Translator's Signature, if applicable