Trailside Health
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111 Bridge St.
Shelburne Falls, Ma
413-625-6240

Consent to Care - Required by Your Government & Courts

I _____ am presenting myself for diagnosis and treatment by this not for profit group and I voluntarily consent to the rendering of such care including diagnostic procedures and medical treatment by its physician and authorized members or designees as may in their professional judgment be deemed beneficial or necessary. I acknowledge that no guarantees have been made to me as to the effect of any such examinations or treatment; I understand any special procedure or treatment involving appreciable risk will be explained to me and that I may at any time discuss or decline such treatment. [] No

I authorize this healer to provide a copy of my record for this visit and reports of any tests done during this visit to my other professional care givers to encourage continuity of care. [] No

I understand that with the increased use of electronic communication and technology relevant patient information may be faxed, electronically viewed, and collected by those directly involved in my care and I authorize release of such electronic information as required for my direct care and as proscribed by law for public health organizations and payment agencies. [] No

I authorize any group hospital insurance, Medicare, Medicaid or health and accident insurance carrier covering my situation to have access to and make copies of this healer's records pertaining to the case, and I authorize release of such information as may be necessary for the completion of health care claims to said carriers. [] No

I authorize the payments of medical benefits, as described in the policy identified in my medical record, directly to Trailside Health and its members. These payments are not to exceed the regular charges for the care provided. I hereby direct the insurance company to forward their payment to Trailside Health. [] No

I understand that I am financially responsible for any and all services rendered to this patient. I also understand that Trailside Health might bill any insurance carrier I designate and that failure of the insurance carrier to pay within thirty (30) days of billing will revert responsibility to me. [] No

I understand that my healing team includes physicians, nurses, counselors, educators and students all of whom have my full permission to discuss all of my health information including my mental health in order to provide comprehensive wholistic care and to constantly improve their care for my health. [] No

If I am unable to pay I have the right to barter in goods or services or arrange to support this not for profit health endeavor in whatever way I may to continue their healing service for me and my community.

My signature below is my acknowledgement (1) that I have read, understood and agreed to the foregoing and this office's HIPAA privacy policies, (2) that I hereby give my authorization and consent and (3) that I am bound by this agreement.

Signed_____ Date_____

Printed Name _____

If the patient is unable to sign or is a minor, please complete the following:

Patient is a minor ____ years of age or is unable to sign because _____

_____

Next of Kin or Legal Guardian _____Witness _____