Annual Authorizations

Consent to Treat & Share Information and Financial Responsibilities

CONSENT FOR EXAMINATION, TREATMENT, PROCEDURE, AND REFERRAL

I agree and give my consent to any medical, dental, & behavior health examinations, treatments, and procedures that the providers and/or his/her assistants may deem necessary or advisable during my appointments. It is understood that this consent does not include operation or surgical procedures which may be found necessary. If such operations or surgical procedures are required during an appointment, I understand that I will be asked to give specific consent for these operations or procedures. I understand by signing this consent I authorize Sadler Health Center Corporation to make disclosures of my protected health information to my other health care providers as needed for treatment and/or coordination of a referral, and/or for continuity of care as deemed to be in the best interest of my health.

CONSENT TO SHARE MEDICAL and/or DENTAL

In the event that our staff may need to discuss medical, dental, or behavioral health issues with you or your family, please provide the names(s) & relationship of those with whom we may speak. This will allow us to maintain your privacy.

Name	Relationship to patient
______________________	______________________
______________________	______________________
______________________	______________________

ASSIGNMENT OF BENEFITS/ NON-COVERED SERVICES/NON-PAR INSURANCE/PCP INFORMATION

1) I authorize and assign all medical, dental, and behavioral health benefits payable for services provided by Sadler Health Center Corporation be paid directly to Sadler Health Center Corporation or its Providers. In the event my insurance company forwards payment directly to me, I will deliver such payment to Sadler Health Center Corporation.
2) If any of the following apply, I may be responsible for all charges incurred.
   a. Current and correct insurance information is not present at time of service
   b. Sadler Health Center does not participate with insurance company (unless patient presents with State Medicaid coverage on date of service)
   c. Prior notice has been given that procedure/visit is a non-covered service
   d. Sadler Health Center does not participate with MA service program listed on Promise Verification at time of service
   e. If covered by Commercial Insurance and/or PA Medical Assistance, I certify I have provided Sadler Health Center with true, correct, and accurate information in order to allow the organization to bill the appropriate payers for services I receive. I will notify the organization of any change of insurance coverage prior to future appointments.
   f. I understand that payment for services may come from Federal or State funds, and that false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.
   g. Additional charges may be incurred by outside agencies for labs.

AUTHORIZATION FOR RELEASE OF INFORMATION FOR BILLING ONLY

I authorize Sadler Health Center Corporation to release such information as may be necessary for the completion of insurance claims relative to my services. I understand that Sadler Health Center Corporation may disclose and release any or all of my medical record to any person or corporation which is or may be liable under a contract to Sadler Health Center Corporation, to the patient or family member, or to the employer of the patient for all or part of the physician's charges. If the patient is eligible he/she will be entered into the Vaccines for Children (VFC) Program.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS.

______________________ ______________________

Patient Name (*please print*) Patient Date of Birth

______________________ ______________________ ______________________

Signature Relationship to patient if minor Date