MORONGO BASIN
COMMUNITY HEALTH CENTER
A SERVICE OF MORONGO BASIN HEALTHCARE DISTRICT

CONSENT FOR TREATMENT

1. Consent for Treatment: Having chosen to be treated by the Morongo Basin Community Health Center (MBCHC) for out-patient services, I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending provider.

2. Prescription History: I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by MBCHC providers and staff and it may include prescriptions back in time several years. **Photography Consent:** I consent to the taking of photographs, video tapes, digital or other images of my medical or surgical condition or treatment, and the use of the images for the purpose of my diagnosis or treatment or for the clinic's operations, including peer review, education, or training programs conducted by the clinic.

3. **Authorization to Release Information:** I hereby authorize MBCHC and all of my attending providers to release information and/or to facilitate the coordination of my health care with appropriate service providers. I understand that MBCHC uses third party resources to attain my medical history when need and that MBCHC may share my data with that third party for medical reasons only.

4. Authorization to Release Insurance Information: I hereby authorize MBCHC and all of my attending providers to release information to complete insurance claim forms.

5. Assignment of Insurance Benefits: I hereby instruct and authorize my insurance carrier to make payments directly to MBCHC.)

6. I understand that I am financially responsible for all charges.

7. I have received a copy of the **MBCHC's NOTICE OF PRIVACY PRACTICES**.

8. As a recipient of federal grant funds to help the underserved communities, Morongo Basin Community Health Center is required to report demographic statistics on an annual basis. This information is reported in total without any individual information. The information provided on this form allows us to count you and your family within a specific income category based on Federal Poverty Guidelines. The Sliding Fee Scale Program is also available if you do not have insurance or are unable to afford your coinsurance or deductible for the services provided.

ADVANCED DIRECTIVES

I understand that it is my responsibility to provide my MBCHC provider(s) with any documents that are required to carry out my Advanced Directives.

I am aware that Advanced Directives may be one of the following:

a. A Durable Power of Attorney for Health Care;

b. The Declaration in the A Natural Death Act (such as a Living Will); or

c. I may write down my wishes on a piece of paper so that my family may use the document, in deciding my medical treatment, in the event I am unable to do so.

SIGNATURES

I have read and confirm the terms of MBCHC's Consent for Treatment, have received a copy of MBCHC's Privacy Practices Notice, and have been offered information regarding Advanced Directives:

Signature of Patient or Legal Representative: _____ Date: _____

If signed by someone other than the patient, indicate relationship: _____

Print Name of Patient or Legal Representative: _____

Signature of MBCHC Representative/Witness: _____ Date: _____