

New Richmond Clinic

AUTHORIZATION FOR TREATMENT: I understand that I have a health concern which requires diagnosis and treatment, and I authorize New Richmond Clinic to provide such diagnosis and treatment. I understand that diagnostic procedures and medical care ordered by my physician are in his/her opinion necessary to treat my health concerns.

PAYMENT AUTHORIZATION: I request that payment be made on my behalf to New Richmond Clinic for services furnished to me by New Richmond Clinic. I authorize New Richmond Clinic to release to the Centers for Medicare & Medicaid Services and its agents, any state Medicaid agency, and any other third party payor all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care and treatment rendered to me that are not covered by insurance.

RECORD RELEASE: I hereby authorize the release of my medical information (including information, if any, about substance abuse, mental health and HIV/AIDS) to my referring provider and any health care provider currently involved in my treatment.

Patient's Printed Name: _____

Date

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor

If signed by patient representative or parent/legal guardian, indicate relationship to patient.