SHERIDAN MEMORIAL CLINICS

1333 West 5th Street
Sheridan, WY 82801
(307) 675-2649

Name (last, first):
DOB: **Age:** **Sex:**
Attending:
FIN: **MRN:**

Sheridan Memorial Clinics Consent for Services

CONSENT TO SERVICES: I, for myself or for this patient, consent to the medical care and treatment which Sheridan Memorial Clinics staff or the attending physician(s) consider necessary.

Photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this. I understand that Sheridan Memorial Clinics will retain the ownership rights to these photographs, videotapes, digital or other images, but that I will be allowed to access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law.

AUTHORIZATION TO RELEASE INFORMATION: By signing this form, you are granting consent to Sheridan Memorial Clinics to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change.

ASSIGNMENT OF BENEFITS: I assign Sheridan Memorial Clinics providers who perform services for me during this visit all benefits which are or shall become payable from any third party payer. I understand and agree that even though I have assigned my benefits to the providers I remain financially responsible for the payment of all medical care and treatment provided to me regardless of any nonpayment or reduced payment any of my third party payors determine to make on my behalf. Payment is due in full by me upon completion of services.

If Sheridan Memorial Clinics submits any claim for services I have received to a third party payor, it does so as an accommodation to me and does not hereby accept any terms, conditions, or limitations such third party payor may wish to apply.

I agree to pay collection expenses or attorney fees incurred in the collection of this account as a result of my failing to pay the same as agreed. I agree to pay an interest charge of 7% annual percentage rate on any unpaid balances. I understand that Sheridan Memorial Clinics reserves the right to assign my account with an unpaid balance for collection.

MEDICARE AUTHORIZATION (if applicable): I request that payment of authorized Medicare benefits be made on my behalf to: Sheridan Memorial Clinics for any services furnished me by that physician/clinic. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

E-PRESCRIBE AUTHORIZATION: I authorize Sheridan Memorial Clinics its employees or agents, to release Medical Information for the following: share and/or receive prescription information with SureScripts (a national prescription database) utilized in electronically prescribing medication for your treatment.

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CONTACT: I consent to be contacted, via the contact information I have provided, by Sheridan Memorial Clinics, its agents, and any entity to which Sheridan Memorial Clinic assigns my account, by regular mail, by e-mail, by telephone (including wireless and mobile telephone numbers), or by text message, regarding any matter related to my healthcare and my account. I also consent to the use of any updated or additional contact information that I may provide as well as to the use of technology including auto-dialing and/or prerecorded messages in contacting me. I also agree to notify Sheridan Memorial Clinics of any changes to my contact information.

_____

Patient's Signature Date Time

_____

Signature Relationship to Patient Date Time