Service Agreement

River People Health Center

AUTHORIZATION TO GIVE MEDICAL CARE- CONSENT TO TREATMENT: I hereby voluntarily consent to outpatient care from one or more areas of the RPHC (River People Health Center) Clinic encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications as prescribed by the Providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by the Primary Care Clinic at RPHC's medical Providers and staff, as is necessary in the medical staff's judgment. I understand that during the course of treatment, health care workers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the clinic at RPHC to release any information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

REQUEST OF RECORDS: I hereby authorize RPHC Providers/support staff to request my medical records from previous healthcare providers in order to be fully knowledgeable of my medical history. I agree to complete Release(s) of Information forms to support these requests as needed or requested by my Provider.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to the RPHC of the clinic benefits otherwise payable to me but not to exceed the clinics regular charges for this period of service. Authorization is not limited to private health insurance but may include other sources such as Medicare and Medicaid, Liability claims and/or reimbursable insurance for any services I receive.

NON-BENEFICIARY FINANCIAL AGREEMENT: I understand and agree with the following: In consideration for the services rendered to me, I am responsible to pay the bill of the clinic services in accordance with the regular rates. Any cost denied by an insurance agent or other responsible party, including co-payments and deductibles will be my responsibility. SRPMIC does not charge for services to those enrolled in a federally recognized tribe.

- Medicaid: I understand that if I do not identify myself as a Medicaid recipient, I will be responsible for this bill.Services not paid or covered under the Medicaid program will be billed to me.
- Medicare: I am expected to pay the Medicare deductible coinsurance. If services rendered are not covered by Medicare or do not meet the requirement of my insurance agency, I will be responsible for the entire bill.

PURCHASED/REFERRED CARE: I have received notice of my Purchase/Referred Care (PRC) eligibility. I fully understand my responsibility under the PRC regulations. I understand PRC is not an insurance program or any entitlement program. I understand that I must comply with the regulations outlined under the alternate resource notice.

CLIENT SATISFACTION: I understand that I may be contacted by RPHC for feedback on the medical or behavioral health care provided to me by a Provider. I also understand that I can complete a Client Satisfaction Survey at any time by clicking on the Client Satisfaction Survey link on the bottom of the www.rphc.org page.

AGREEMENT: My signature indicate that, I agree and understand that contents of the service agreement, my rights and responsibilities as a patient and that I have received a copy of the documents.

Patient Name (Print)	Date	Patient Signature	Date

If Applicable:

Parent/Guardian Name (Print)	Date	Parent/Guardian Signature	Date

Employee Name/Signature	Date	Patient HRN