CONSENT FOR TREATMENT

I give my permission for River Valley Family Health Centers to provide medical, dental, and/or behavioral health services to me or my child named on page four (4). I verify that all the information provided is truthful. I attest the number of dependents is correct on page five (5) (my reported household size). I attest that my income listed is correct. I understand that payment must be made at the time of service.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for the services provided to me by River Valley Family Health Centers. Even if I have insurance coverage, I may owe money in addition to that which was paid by my insurance.

I authorize and direct any holder of medical information or documentation about me or my child to release such information to the River Valley Family Health Centers and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by River Valley Family Health Centers. I authorize payment of third- party benefits directly to the River Valley Family Health Centers for services rendered for myself and/or my dependents.

Signature of Patient _____ Date _____

Signature of Guardian (if patientunder 18) _____ Date _____