



General Consent to Medical Services

Patient Name: _____

Patient Date of Birth: _____

I request and authorize Knox County Community Health Center (KCCHC) and its personnel to deliver routine medical care that may be deemed necessary or advisable in my diagnosis and treatment. I understand that a KCCHC provider will review my history before making any new diagnoses. I acknowledge that no guarantees have been made to me as the result of any examination or treatment and that I can ask my provider questions about my treatment. I give consent for my KCCHC provider to diagnose or treat me as deemed appropriate.

ASSIGNMENT OF INSURANCE BENEFITS/THIRD-PARTY PAYORS:

In consideration of the medical services rendered or about to be rendered to me, I hereby assign to KCCHC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payors of an amount not exceeding KCCHC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payors, and other third parties. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or another third-party payor.

FINANCIAL RESPONSIBILITY:

KCCHC will provide medically necessary medical services regardless of a patient's ability to pay. Patients with demonstrated financial need may be eligible for discounted services. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need, and take into account the patient's available income, household size, and all other financial resources available to the patient. I understand that if patients are ineligible for financial assistance, then they will be responsible for the costs of services that are their financial responsibility. I understand that payment is expected at the time of treatment.

I voluntarily give my consent to routine medical services as stipulated above. I have been told to contact KCCHC should I have any questions or concerns after this treatment.

Signature

Date

Print Name

(Relationship to Patient, if applicable)