COMMUNITY HEALTH INTERVENTIONS, INC. SPECIALTY CLINIC

ADULT PATIENT CONSENT FORM

Thank you for allowing Community Health Interventions, Inc. Specialty Clinic to serve you. Please complete this consent form and provide proper documentation of insurance in order to receive services.

CONSENT FOR TREATMENT
I hereby give my consent to receive comprehensive health services at Community Health Interventions, Inc. Specialty Clinic. I further authorize any health professional working for Community Health Interventions, Inc. Specialty Clinic to provide medical tests, procedures, and treatments that are necessary or advisable for the medical evaluation and management of my health care. This includes examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Community Health Interventions, Inc. Specialty Clinic personnel under the instructions, orders or direction of such physician(s). Treatment may be in the form of office visit, telemedicine or telehealth visit by licensed provider.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby assign and authorize payment of all of my insurance benefits, sick benefits, Medicare benefits and injury benefits due because of liability of a third-party, payable by any party or organization directly to Community Health Interventions, Inc. Specialty Clinic or any Community Health Interventions, Inc. Specialty Clinic-based physician, unless the account for the facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I understand that I am responsible for any charges not covered by my insurance company.

PROMISE TO PAY
I understand that I am obligated to pay in full for any services received in accordance with the regular rates and terms of Community Health Interventions, Inc. Specialty Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Community Health Interventions, Inc. Specialty Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received a copy of the Community Health Interventions, Inc. Specialty Clinic's Notice of Privacy Practices that provides information about how the Community Health Interventions, Inc. Specialty Clinic may use and disclose my protected health information. I have read and understand the above information and give permission for my care as described. I understand that I have the right to OPT-OUT of any medical testing or treatment. I also understand that I may obtain further information regarding the health services offered by Community Health Interventions, Inc. Specialty Clinic by contacting 910-488-6118.

_____	_____
Patient Name	**Date**
_____	_____
Patient/Legal Representative Signature	**Date**
_____	_____
Witness Signature	**Date**