MID-DELTA HEALTH SYSTEMS

Clarendon	DeWitt	Stuttgart
245 Madison St	1940 S. Whitehead Dr	1012 E 22 St
Clarendon, AR 72029	DeWitt, AR 72042	Stuttgart, AR 72160
Tel: (870) 747-3381	Tel: (870) 946-4505	Tel: (870)659-2600

Consent to Treatment

_____ _____

PATIENT NAME DATE OF BIRTH

CONSENT: I hereby consent for myself or for whom I am legally responsible for, to receive to outpatient care provided by Mid-Delta Health Systems which may include but not limited to diagnostic procedures, examinations, and/or treatment by MDHS's providers and/or other staff of the clinic.

RELEASE OF INFORMATION: I authorize Mid-Delta Health Systems to release medical information to third party insurance carriers for the purpose of filing claims, and to release or obtain medical information to/from providers of medical care and the Health Department for the purpose of continuity of care. I authorize payment of medical benefits by my insurance to Mid-Delta Health Systems.

PRESCRIPTION HISTORY CONSENT: This facility participates in the Prescription Drug Monitoring Program. Clinicians in this office will not prescribe narcotics, benzodiazepines, or controlled medications for chronic use. I authorize Mid-Delta Health Systems to obtain and review my prescription history from pharmacies, other providers, and other third-party entities such as insurance companies.

TRAINING FACILITY: I understand that occasionally health care students may be working with my provider. I give consent to have a health care student observe or participate in my care while under the supervision of my provider. I understand that these health care students are under the same confidentiality policies as my provider. I acknowledge that I have the option of declining the consent.

EFFECTIVE PERIOD: I understand this consent/authorization will be valid and remain in effect as long as I attend the clinic or until I revoke this authorization in writing.

Medicaid/ARKids: I understand that if I have Medicaid, this facility must be designated as my Primary Care Physician. If Mid-Delta Health Systems is not my PCP, I acknowledge that I must obtain a referral for services from my PCP or the full amount of services will be due at the time of visit. I understand I am responsible for ANY services not covered by Medicaid or ARKids.

Medicare: I understand that I will be responsible for any service or lab not covered by my Medicare or Medicare replacement plan.

Sliding Fee Scale/Self-Pay: I understand that Mid-Delta Health Systems offers reduced fees on a sliding fee scale based on household income. If I wish to apply for the sliding fee scale, I will fill out the provided form and return my proof of income within 48 hours of visit. If I qualify for reduced fees, I understand that I will be asked to pay an initial fee of $20 for medical or $35 for dental at check in. Any remaining charges will be collected at check out. If I do not have insurance and do not qualify for the sliding fee scale, I will be asked to pay a set fee of $20 for medical or $35 for dental at check-in and additional charges at check-out.

IF YOU ARE UNABLE TO PAY ANY OF THE ABOVE FEES AT THE TIME OF YOUR VISIT YOU MAY BE RESCHEDULED.

By signing below, I am acknowledging that I am the patient or the authorized representative for the patient.

_____ _____

Signature of Patient (or Parent/Legal Guardian) Date

_____

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Relationship to patient if patient is unable to give consent.