RIVERSTONE HEALTH CLINIC

CONSENT FOR TREATMENT /ASSIGNMENT OF BENEFITS

Patient Name: ________________________________ Birthdate: _____________________

I hereby request and authorize RiverStone Health Clinic to assess, evaluate, and provide care and treatment to the patient listed above. I understand that I may be treated by a behavioral health provider as part of my medical care and that these encounters will be a part of the medical record. I understand that a licensed clinical pharmacist may participate in my care and as part of my care team to provide, among other benefits, drug therapy management.

_____ (Initial Here) I authorize my health care provider and public health agency to collect and enter immunization records into the Montana Department of Public Health and Human Services' confidential Immunization Information System registry. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in medical care and treatment. In addition, children's immunization information may be released to child care facilities and schools to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

I authorize RiverStone Health to access prescription history from outside sources, including but not limited to SureScripts.

I further understand that I am responsible for the costs of my care. I understand that RiverStone Health Clinic offers a Sliding Fee Scale based on family income; if I qualify for the Sliding Fee Scale, I acknowledge that I remain responsible for the remaining balance for my care. I hereby assign any of my health insurance benefits to be paid directly to RiverStone Health Clinic. I hereby authorize the release of medical information related to the payment of those insurance benefits.

I acknowledge that RiverStone Health Clinic is a Patient Centered Medical Home. I will be asked to select a primary care provider and understand that I will be an active participant in my care.

Signature: ____

Date:____

Updated 8/31/2017