K'ima:w Medical Center

An Entity of the Hoopa Valley Tribe

PO Box 1288
535 Airport Rd.
Hoopa, CA 95546
Phone: (530) 625-4261

General Consent for Treatment and Third-Party Billing

I hereby grant permission to the health care staff of K'ima:w Medical Center to employ such established health care treatment and therapy as may be deemed necessary or advisable in the diagnosis and treatment of:

Name of Patient:_____ DOB:_____Chart Number:_____

This authorization shall remain in full force and in effect for one year from this date and will be renewed annually or as needed and, hereby authorize staff of K'ima:w Medical Center to share health and demographic information contained in my medical records to any consulting health care provider and/or to my insurance company for reimbursement.

I hereby assign payment authorizing Medicare/Medi-Cal/Insurance benefits be paid directly to K'ima:w Medical Center. I understand that I am financially responsible for all charges whether or not to be paid by said insurance.

New Federal rules regarding medical information protection, which have been effective since September 13, 2013, are available and have been offered to me.

I understand that K'ima:w Medical Center is a teaching institution and I hereby agree to the occasional supervised observation of my health care with an appropriate medical student, nursing student, resident physicians, physician S

If you have any further questions, you may contact the HIPAA Compliance Officer at (530) 625-4261 or your provider.

_____ _____
Patient Signature Date

I attest to the fact that I am the parent/legal guardian of above-named patient.

_____ _____ _____
Parent/Legal Guardian Signature Relationship Date

_____ _____
K'ima:w Employee Signature Date