Storm
CLINIC

CONSENT TO TREATMENT
AND
FINANCIAL RESPONSIBILITY

CONSENT TO TREATMENT:

I consent to be treated by the medical staff at the Clinic, subject to my informed consent. I understand I have the right, as a patient, to be informed about my condition and the recommended surgical, medical or diagnostic procedure to be performed and any attendant risks and hazards so that I may make the decision whether to undergo any suggested treatment or procedure. I understand it is my responsibility to ask questions when my treatment is being conducted.

I understand this consent provides the Clinic with my permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, I am indicating that (1) I intend that this consent be continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. I understand I have the right at any time to discontinue services. I further understand I have the right to discuss the treatment plan with my physician about the purpose, potential risk and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommended by my health care provider, I understand it is my responsibility to ask questions.

CONSENT TO FINANCIAL RESPONSIBILITY: *I consent to pay my copayment and deductible prior to receiving service at the Clinic and to pay any charge or portion thereof associated with my treatment at the Clinic not covered by my insurance plan. If I do not carry insurance, I consent to pay all charges associated with my treatment. I understand that I am responsible for knowing my coverage benefits, and for paying any charges that work comp does not cover.*

I acknowledge the Clinic will send its billing statement showing any remaining balance due on my account once a month. I agree to pay the balance within 30 days and will contact the Clinic at 605-271-5441 with any questions about charges or statements.

If you have insurance coverage: I understand that I am responsible for paying my copayment and deductible before service. I understand that if I cannot pay my copayment and deductible prior to service, the Clinic will still provide medical service. I understand that if there are any changes in my insurance coverage, I must let the Clinic know immediately so it can submit my claim properly. I give consent to the Clinic to call my insurance and send my records, if requested; to get my service covered.

I understand that most insurance plans will not cover services considered investigational, experimental, or cosmetic and that there may be services not covered. I understand that if my insurance coverage is dropped, I will be required to pay for the office visit charge and will be billed for any adjustments to the office visit and for any additional services received. Additional services include: lab, x-ray, CT, immunizations, travel medicine encounters, injections, etc. Any payments collected will be applied towards my balance.

If you do not have insurance coverage: I understand that I am responsible for payment at time of service. I understand I am required to pay for an estimated office visit charge and will be billed for any adjustments to the office visit and for any additional services received. Additional services are listed above.

By signing below, I affirm that I have read, understand, and agree to the contents of this Consent to Treatment and Financial Responsibility.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Rep. Relationship to Patient