Indian Health Council
50100 Golsh Rd
Valley Center CA 92082
760-749-1410

Empowering Native Wellness

Chart # _____

Consent for Treatment & Assignment of Benefits

1. Consent to Medical, Dental, Psychological, Nursing and Surgical Procedures:
   The undersigned consents to the patient entering the IHC Facility and receiving medical, dental, psychological, general duty nursing or surgical procedures, which may include emergency services, laboratory procedures, x-ray examinations, anesthesia and other procedures under the general and specific instructions of the patient's healthcare provider(s). The undersigned acknowledges that the patient or the legal representative of the patient will be required to sign additional consent forms for complex treatments and procedures which require the patient's provider to obtain informed consent from the patient or the patient's legal representative for such treatment or procedures.

2. Release of Patient Information:
   The IHC Facility will not release patient identifiable information to any third party without the patient's written consent, except as permitted or required by law: The undersigned agrees that the Facility may release information without a patient consent, to the extent necessary, (1) to insure continued treatment by healthcare providers and (2) to determine who is responsible for payment and to obtain payment or reimbursement for services provided to the patient; Third parties who may receive such information under this paragraph include insurance companies, utilization reviewers, case managers, federal and state agencies, consulting and treating providers, patient's employer and managed care plans who are responsible for payment of covered services. (Psychological/HIV/AIDS information will require a special consent prior to release).

3. Payment for services rendered:
   I, the undersigned, certify that the information given to the IHC Facility in applying for payment by third parties is correct. I hereby authorize payment of benefits on my behalf for services furnished to me and authorize the IHC Facility to release minimum necessary patient health information pertaining to the visit to the Health Care Financing Administration or to the California Department of Health Services or other agents which is necessary to determine benefits or payment for services under these programs.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____
Patient/Legal Representative

Relationship to Patient: _____