Consent for Treatment and Billing

Date:_____

Columbia Health Services is the medical sponsor for the following clinics. I hereby authorize the Columbia Health Services, to provide health services to:

Patient Name_____ ☐ My child ☐ Me at the following locations (check all that apply)

❒ **Main**
2370 Gable Rd.
St. Helens, OR 97051
(503) 397-4651

❒ **Clatskanie SBHC**
471 SW Belair
Clatskanie, OR 97016
(503) 728-5181

❒ **Spencer Health and Wellness**
1000 Missouri Ave.
Vernonia, OR 97064
(503) 429-1399

❒ **Rainier Health Center**
28168 Old Rainier Rd.
Rainier, OR 97048
(503) 556-2178

❒ **Sacagawea Health Center**
1060 Eisenschmidt Ln.
St. Helens, OR 97051
(503) 366-7645

I understand that:

- No patient will be turned away if unable to pay for the services provided.
- Each patient or appropriate patient representative has the right to refuse consent for treatment.
- Absent emergency or extraordinary circumstances, no substantial procedures are performed unless there is a discussion of the treatment with the physician or other health care professional.
- Columbia Health operates according to the guidelines set forth by Oregon Law. The law states that patients age 15 and older may sign their own consent for medical treatment. Patients under 15 years old need a parent or guardian's signature except for family planning and sexually transmitted disease services. ORS 109.610, ORS 109.640, ORS 109.675

For patients being seen in school-based health centers:

The Health Center staff will attempt to contact parents when their child has visited the health center. Minors are also encouraged to discuss their medical care with their parents. By signing this consent, I am allowing my school-based health center to access the Emergency Contact Form submitted to my school district. This clinic is a partnership between Columbia Community Mental Health and Columbia Health Services. Information for treatment, payment, and health care operations will be shared between agencies.

Insurance and Payment (please read and sign):

- I understand that I am responsible for the terms and conditions of my individual insurance plan.
- I authorize my insurance benefits be paid directly to Columbia Health Services
- I authorize Columbia Health Services to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.
- I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.
- Without insurance, I understand that Columbia Health Services will send me a bill for the services I receive. I am responsible to pay for those services. I will ask about the Financial Assistance program if I need assistance.

_____ _____ _____

Date *Signature of Patient or Responsible Party* Printed Name

Patient refuses to sign consent_____ Staff Initial and Date _____