Pueblo Community Health Center

Consent to Treat/Bill
(Please complete one form per patient)

I authorize release of Protected Health Information necessary to obtain payment, provide treatment and to conduct healthcare operations as described in PCHC's Notice of Privacy Practices.

I consent for the clinician to treat my medical, behavioral health and/or dental condition.

I authorize payment of benefits to PCHC for services rendered and agree to pay all balances due, including collection costs.

I consent to be contacted by regular mail, by email or on my phone (including my cell phone) regarding any matter related to any account where I am the guarantor at PCHC, its successors, or outside agency as assigned by PCHC. This consent includes any updated or additional contact information that I may provide and includes phone calls that employs auto-dialer technology and prerecorded messages. This consent applies to all PCHC healthcare providers. If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by mailing such revocation to Pueblo Community Health Center, 110 E. Routt Ave., Pueblo, CO 81004.

______________________________ Patient Name (Please Print)

______________ Patient DOB

______________________________ Patient Signature

______________________________ Parent/Guardian Signature

______________________________ Parent/Guardian Name (Please Print)

______________________________ Date Signed

Consent to Treat/Bill must be signed annually by patient.

AUTHORIZED USE ONLY

Staff Initials: ____________________ Dept: ____________________

Date sent to Medical Records: __________ Med Rec Clerk Initials: ______ Scanned Date: __________