Your Care
your health
3818 SW 21st Place, Suite 100, Redmond, OR 97756
(O) 541-548-2899 (F) 541-504-3781

Your Care, LLC- HIPAA Information and Consent for Medical Treatment

Patient or Patient's legal representative agrees to the following terms of treatment:
I, the patient or authorized representative, consent to any examination, evaluation and treatment regarding my illness, injury or other health concern affecting me at the time of check in at Your Care, LLC. These services may include, but are not limited to laboratory procedures, x-ray examinations, and medical or surgical treatment or procedures. I am a patient, the parent of a minor child, or the legally authorized representative of the patient and I authorize Your Care, LLC to submit an insurance claim on my behalf. I understand that I am financially responsible for any non-covered service. I have read and understand this treatment agreement. _____ **(Initial)**

Payment is required at the time of service and may be in the form of cash, debit, or credit card. Your Care, LLC does not accept personal checks. I authorize Your Care, LLC to submit a claim to my insurance carrier for me and I assign all insurance payments to Your Care, LLC. I understand I am financially responsible for any charges not covered by my insurance. _____ **(Initial)**

I give my permission to Your Care, LLC to release medical information, prescription information, and/or other information contained in my or my child's medical records to the person(s) listed below.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ **(Initial) I decline having anyone listed to assist with my healthcare.**

I authorize Your Care, LLC to communicate with other health care providers in connection with my medical treatment. _____ **(Initial)**

I, _____ do hereby consent and acknowledge my agreement to the terms set forth the in the HIPPA Information and Consent for Medical Treatment form and any subsequent changes in office policy. I understand this consent shall remain in force from this time forward.

Signature: _____ **Relationship to Patient:** _____

Witness (staff): _____ **Date:** _____