1ST CHOICE HEALTHCARE
Revolving around you

PATIENT NAME _____ **DATE OF BIRTH** _____

AUTHORIZATION TO GIVE MEDICAL CARE AND/OR BEHAVIORAL HEALTH CARE:

I hereby agree and consent to evaluation and treatment for myself and/or my child(ren) including any medical treatments, studies, or procedures or behavioral health services deemed medically appropriate by 1st Choice Healthcare, Inc. providers. If signing as a parent or guardian, I hereby represent that I am legally empowered and entitled to make such decisions.

Treatment of Minor:

If I, (parent/legal guardian) _____, cannot accompany my child, (child's name), _____, to 1st Choice Healthcare, I give permission to the following people to seek medical treatment for my child:

_____	_____
Name	Name
_____	_____
Name	Name
_____	_____
Name	Name

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:

I understand that my personal health information serves as a basis for planning my care and treatment and is a source of information regarding all medical treatment and diagnosis therefore; I authorize 1st Choice Healthcare, Inc. to release information to third party payers/insurance carriers for claim filing and payment purposes.

NOTIFICATION OF FINANCIAL POLICY:

Insurance:

If you have health insurance, our office will file your claim for you. You will be required to pay your co-pay or any deductible not met, at registration. If you do have a deductible to meet, you will be required to pay a fee of $20.00 at registration and any remaining charges at the time of check-out.

Medicaid or Arkids:

If you or your child is enrolled in the *Medicaid* or *ARKids First* Program, this facility must be designated as your primary care physician. If we are not your primary care physician, then you must obtain a referral prior to being seen, or the full amount will be due at the time of your visit.

OVER

Sliding Fee Scale:

The Sliding Fee Scale program is based on your **total household income.**
If you qualify for any of our levels, you will be required to pay a fee of $20.00 at registration and any remaining charges at the time of check-out.

Self Pay:

If you do not have insurance and do not qualify for the Sliding Fee Scale program, you will be required to pay a fee of $20.00 at registration and any remaining charges at the time of check-out.

IF YOU ARE UNABLE TO PAY ANY OF THE ABOVE FEES AT THE TIME OF YOUR VISIT, YOU MAY BE ASKED TO SPEAK WITH OUR COLLECTIONS COUNSELOR.

Consent to use Patient Portal:

Before you were given this form, we provided you with our Policy and Procedures for using the Patient Portal. By signing this form below you will acknowledge that they were explained to you and that you understand and agree to comply with them. If you do not understand, or do not agree to comply with our Policy and Procedures, do not sign the form. If you have any questions, we will gladly provide more information.

Patient Information:

Name: _____Date of Birth:_____

Address: _____

Email Address: _____

I UNDERSTAND THIS CONSENT REMAINS IN EFFECT UNTIL I REVOKE IT IN WRITING.

_____ _____
Patient/Guardian Signature Date

_____ _____
Signature of Witness Date