galion city
HEALTH DEPARTMENT

113 Harding Way East
Galion, Ohio 44833

Phone 419.468.1075
Fax 419.468.8618
www.galionhealth.org

Patient Name: _____ Date of Birth: _____

Consent to Treat

I grant permission for requested services to be completed today.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my condition or the above-mentioned minor's condition for whom I am the parent/guardian.

I voluntarily consent to medical care of a routine/emergency nature from the authorized professional staff of the Galion City Health Department for myself or the above-mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my medical evaluation to those individuals that my doctor feels appropriate for my continued medical care.

I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available.

It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Financial Agreement

If applicable, I authorize the Galion City Health Department to submit claims to my insurance company. I authorize payment of medical benefits to the Galion City Health Department for services administered, which would otherwise be payable by me and which were established by my insurance company. The amount paid to the Galion City Health Department shall not exceed the practice's regular charges for the services. I also authorize the release of my medical records to my insurance company/companies or other third-party payers or my employer as required for the collection of payments. I further understand that I am responsible for any co-pays, co-insurance, deductibles, and/or non-covered charges as determined by my insurance carrier.

The Galion City Health Department requests that you read your insurance policy and be fully aware of any limitations of the benefits provided. You should be aware that the insurance agreement is between you and the insurance company. It is the patient's responsibility to know the limitations of his/her policy. Any charge incurred beyond the reimbursement of your policy will be your financial responsibility.

I have read the above and understand my financial obligation.

Signature: _____ Date: _____