Valley-Wide Health Systems, Inc.
Your Health, Our Priority!

Consent to Treat and Assignment of Benefits to Valley-Wide Health Systems, Inc.

Legal Name: Last_____First_____M.I._____

Birth Date: _____ Sex: _____ Email: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

SMS Phone: _(_____)_____ Current Insurance:_____

Valley-Wide Health Systems, Inc. provides treatment and care through an integrated model. Valley-Wide Health Systems provides whole person care by a care team which, in our system, includes various aspects of physical health, behavioral health, and support services.

I consent to treatment and care by Valley-Wide Health Systems Inc. I understand that treatment and care in an integrated model may include any or all routine health maintenance services (including immunizations, screeners, introduction to other service providers in our system, and/or external referrals) for acute and chronic health conditions depending on my condition. These services may include any of the following departments: medical, dental, physical therapy, behavioral health and pharmacy. I have also received written information on how to contact Valley-Wide in the event of an emergency or crisis situation.

I understand that the services authorized by this consent include those provided under the auspices of Valley-Wide Health Systems by physicians, nurse practitioners, physician assistants, medical technologists, behavioral health providers, physical therapists, physical therapist assistants, dentists, dental hygienists, dental assistants, nurses, health educators, medical assistants, and pharmacists. I understand that my care team may include health professionals-in-training under the supervision of a licensed and responsible health professional practicing within the scope of their education, training and certification**.**

I understand that I have the right to refuse any or all services in any combination, or by any member of the treatment team. I understand I have the right to discuss any treatment plan with my care team about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommend by my care team, I am encouraged to ask questions.

I also understand that my medical records for all services described above are maintained within a single location and may be shared across each service line described above. These records are to be kept confidential and the release of any health information is protected under and will conform to privacy laws under HIPAA and/or 42 CFR Part 2.

I hereby authorize payment directly to Valley-Wide Health Systems, Inc. for healthcare benefits. I understand that I am financially responsible to Valley-Wide Health Systems, Inc. for services not paid by insurance or other third party payors. I understand that if I have been issued a refund check and I fail to cash a refund check or the refund check is returned as undeliverable after reasonable attempts to contact have been unsuccessful, such check will be considered a donation to Valley-Wide Health Systems.

I consent to health professionals-in-training participating in my health care, within the scope of their education, training and certification and under the supervision of a licensed health professional. ☐ YES ☐ NO

I understand that I may revoke this consent at the time of my visit. ☐ YES ☐ NO

Signature of Patient or Guardian (if required): _____ Date: _____