670 Park Avenue,PO Box 990 Shelby, Mt 59474
406-434-3100, Fax 406-434-3143

AUTHORIZATION FOR TREATMENT:
The undersigned has been informed of the treatment considered necessary for the patient and the treatment and procedures will be performed by physicians, members of the house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned understands that a personal Physician is to be selected by or on behalf of the patient within 24 hours if hospitalization or further treatment is required, or immediately if complications arise. The undersigned has read the above authorization and understands that no guarantee or assurance has been made as to the results of the treatment.

MMC CONSENT:
Patient understands that tests will be provided to MMC unless instructed by patient. Patient understands that they will be liable financially from MMC for their services.

AUTHORIZATION FOR RELEASE OF INFORMATION:
Authorization is herby granted to release to the within names insurance companies such information as may be necessary for the completion of my claims. I authorize the Toole County Health Department to collect and enter my child(ren)'s immunization records into the Department of Public Health and Human Services' Immunization Information System. This is a confidential computer system that contains immunization records. I understand that information in the registry may be released to local health departments as well as my health care providers to assist in my child's medical care and treatment. In addition, information may be released to the child care facilities and schools in which my child is enrolled to comply with state requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

ASSIGNMENT OF INSURANCE BENEFITS:
For valuable consideration, I/We herby authorize payment directly to Marias Healthcare Services Inc for the clinic benefits as set forth by the policy within and otherwise payable to me, but not to exceed the regular charges for this clinic visit. I understand I am financially responsible for charges not covered by these assignments. I further direct my insurance company to forward their check direct to the above name facility. I herby state that the list within is the complete list of my insurance companies. I understand that the clinic will make an additional charge for making claims to insurance companies other than those listed.

HEALTH INFORMATION PRIVACY:
I understand that I can obtain a copy of the Marias Healthcare's Notice of Privacy Practice brochure, which informs me of the potential uses and disclosures of my health information as well as my rights in relation to such records. The Undersigned has read and agree to the above authorization and information.

I do hereby acknowledge that I have received a copy of Marias Healthcare's Clinic *Notice of Privacy Practices* for and in behalf of myself and those for whom I am guarantor. I understand that by law (FPR 45 CPR § 164.524) my records are protected and that disclosure in most instances requires my signed permission.

<<patient>> January 18, 2016

Patient Name (printed) **Date**

Double-Click to Sign

Patient Signature (or guarantor if patient under 18)

Guarantor Printed Name (& relationship to patient if under 18)