Public Health
100 Years of Service • 1913-2013

Pt. Name:______________________
DOB:_________________________
SS#:__________________________
(*or attach label*)

ACKNOWLEDGEMENT AND CONSENT FORM

________ **Acknowledgement of Receipt of the Notice of Privacy Practices**
I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices for Durham County Department of Public Health and understand that I may contact the person named therein if I have questions about the content of the notice.

________ **Consent for Treatment**
I hereby certify in the event medical treatment is needed, such treatment shall be fully explained to me, to my satisfaction, by the Durham County Department of Public Health medical personnel and/or other provider; therefore, I consent to said treatment by the Durham County Department of Public Health medical and healthcare personnel.

________ **Insurance/Payment Information**
I hereby authorize and request that payment of Medicaid, Medicare and any other Third Party benefits that I am entitled to be paid directly to Durham County Department of Public Health for all services furnished to me by any of the providers employed or contracted with by that facility. I hereby certify that the information provided concerning my income is true and complete and that I have no income other than what I have provided. I understand that I am responsible for any charges not covered by this assignment or charges that are specifically excluded from coverage by Medicaid, Medicare or the private insurance listed below.

Check all that apply: ☐ Medicaid ☐ Medicare Part B
☐ NC Health Choice ☐ Other Insurance Carrier
____

______________________________ ______________________________
Name of Beneficiary Policy/ID Number

For Third Party Coverage:

______________________________ ______________________________
Name of Policy Holder Group Number

____
Claims Mailing Address

My signature indicates that I agree to all of the initialed items above.

______________________________ ______________________________
Signature of Patient/Parent or Legal Guardian Signature of Witness

______________________________ ______________________________
Date Date