Pyramid Lake Tribal Health Clinic

Post Office Box 227
Nixon, Nevada 89424
Telephone: (775) 574-1018

CONSENT FOR GENERAL CARE
AND
AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby grant permission to the staff of the Pyramid Lake Tribal Health Clinic to employ such established treatments and therapy as may be deemed professionally necessary or advisable in the diagnosis and treatment of:

[NAME OF PATIENT] ____
Please Print

This authorization shall remain in effect for this and future outpatient visits unless the consent is cancelled by my personal written notice and filed with the Pyramid Lake Tribal Health Clinic, P.O. Box 227, Nixon, NV 89424.

[Circle Yes – No] *I hereby authorize the Pyramid Lake Tribal Health Clinic, its staff, to give any/and all information contained in my medical record to the referring physician and/or to insurance companies or other agencies to which claim is made for coverage.*

[Circle Yes – No] *I hereby agree to supervised involvement in my health care by medical and nursing students, resident physicians, and other students of the health care sciences.*

________________________________ ________________ ________*am/pm*
Signature of Consenting Patient *Date* *Time*

Please sign below if patient is a minor
"I attest that I am the legal guardian of said patient":

________________________________ ________________________
Legal Guardians Signature *Relationship to Patient*

________________________________ ________________ ________*am/pm*
Witness Signature *Date* *Time*

A COPY OF THIS CONSENT IS AVAILABLE UPON REQUEST

Acknowledgement of Receipt of PLTHC Notice of Privacy Practices

I hereby acknowledge receipt of the Pyramid Lake Tribal Health Clinic Notice of Privacy Practices at:

Pyramid Lake Tribal Health Clinic
705 Highway 446/ P.O. Box 227
Nixon, Nevada 89424

______________________________ ______________

Signature of Patient *Date*

______________________________ ______________

Signature of Patient Representative *Date*
Relationship to Patient: ______________________
Or Witness (if signature is by thumb print or mark)

______________________________ ______________

Signature of Pyramid Lake Health Employee *Date*
Title: ______________________________

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the PLTHC Notice of Privacy Practice because: ______________________________

______________________________ ______________

Signature of Pyramid Lake Health Employee *Date*

STATEMENT TO PERMIT PAYMENT OF BENEFITS

(PRIVATE INSURANCE, MEDICARE, MEDICAID OR OTHER ALTERNATE RESOURCES)

TO PYRAMID LAKE HEALTH CLINIC

Assignment and Release:

I hereby authorize my insurance benefits be paid to the Pyramid Lake Health Clinic. I also authorize the providers to release any information required in processing the claim(s) for myself or my dependents outpatient visits at the Pyramid Lake Health Clinic.

____

Name of Insurance Carrier

____

Name of Policy Holder

______________________________ ______________________________

Name of Insured (Card Holder) *Relationship (Spouse/Dependent)*

______________________________ ______________________________

Signature of Patient or Authorized Representative *Today's Date*