COMMUNITY
HEALTH PARTNERS

Agreement and Authorization for Services Consent Form

V. Assignment of Benefits and Agreement to Cooperate in Collection Efforts

In consideration of the healthcare services provided to me by Community Health Partners, I hereby assign Community Health Partners, physicians, and other professionals associated with Community Health Partners all of my rights and claims for reimbursement under Medicare, Medicaid, or group accident or health insurance policy for which benefits may be available for payment of the services provided. In addition, I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by any reimbursement source to effectuate, perfect, confirm or validate my assignment and authorization of Community Health Partners as my assignee and authorized representative, and to assist Community Health Partners with pursuing payment from any reimbursement source.

VI. Guarantee of Payment

I understand and agree that I am financially responsible for any and all charges related to any services rendered. While my claims may be paid by the above-mentioned coverage sources, I recognize that payment is not guaranteed and that I am ultimately responsible to pay Community Health Partners, physicians, and other professionals associated with Community Health Partners the balance due of all charges not paid for by the above mentioned coverage (excluding those charges not collectible pursuant to Medicare regulation). This may include costs of collection and/or reasonable attorneys' fees. I have read each of the foregoing, I-VI and fully agree to each of the statements and agreements herein, which may include inpatient treatment after emergency or outpatient care, by signing below as my free and voluntary act.

VII. Consent to Photograph

I hereby consent to be photographed while receiving treatment at Community Health Partners (CHP) Practices.

I understand that the images form such photography may be used for my treatment or for hospital health care operations such as peer review or medical education, as the hospital or my treating provider(s) deem appropriate. The use of such images is subject only to the following limitations:

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The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I further understand that I must obtain consent from my treating provider(s) if I request that a procedure or treatment be photographed by CHP personnel. I also understand that the photography and photographs will be maintained in my electronic health record.

Patient	Date
Guardian if patient is under 18 years old	Date
Other (record relationship to patient)	Date
Witness	Date