VALLEY WOUND HEALING CENTER

PATIENT NAME:_____ **DATE:**_____

PAYMENT AGREEMENT

Initial_____ I authorize the doctor to deposit checks received on Patient's account when made out to the patient.

PRIVACY PRACTICE CONSENT FORM

Initial_____ **Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your personal health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: A copy of our notice is available in our office for your review.

I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my personal health information to carry out treatment, payment activities and health care operations. I also understand that if I refuse to sign this consent, we may be unable to provide you treatment. A copy of this office's Notice of Privacy Practices has been made available for my review.

CONSENT TO PHOTOGRAPH

Initial_____ I consent that photographs may be taken. In connection with the services I am receiving from Valley Wound Healing Center. I understand the necessity for the photographs, and that they shall become part of my medical records. These photographs shall be used for the purposes of treatment shared only with health care professionals, or for administrative uses of Valley Wound Healing Center.

CERTIFICATION OF ELIGIBILITY

Initial_____ I understand that I am eligible for insurance benefits with:
_____(name of insurance company(ies)
It is my understanding that these benefits became effective on or as of today's date. I am aware that if the above is not true, I (or the person responsible for me) will be responsible for all charges related to services provided to me. I agree that if the above is not true, (or the person financially responsible for me) will pay in full for all such charges.

PATIENT/RESPONSIBLE PARTY'S SIGNATURE:_____
PATIENT'S DATE OF BIRTH:_____
DATE:_____