CityLife Health

Community Care Consent for Treatment

CityLife Health offers preventative care & screenings to members of our community. In order to receive such preventative care, please complete this form in its entirety.

Patient Name: _____ **Date of Birth:** _____

Name of Parent or Legal Guardian (if patient is under 18 years of age): _____
Relationship to Patient (circle one): Mother/Father/Legal Guardian

I give my permission for CityLife Health to perform the following screening tests (check all that apply):

- ☐ Physical exam for school, daycare, or sports physical
- ☐ Flu vaccine
- ☐ COVID-19 vaccine
- ☐ School mandated vaccines

I hereby release, discharge, and agree to hold harmless CityLife Health, CityLife-PA, P.C., Ampersand Health-PA, LLC, and their affiliates, employees, agents, officers, directors and representatives from all damages, losses, injuries, or liability whatsoever which may arise from my participation in preventative care and screenings listed above.

Assignment of Benefits and Financial Responsibility

I assign to CityLife Health, and any health care provider providing care and treatment to me, my child, or any person entitled to health care benefits for the care and treatment provided, and all benefits for services provided under any insurance policies, including but not limited to Medicaid, Medicare, or any reimbursement from a health care plan. I understand that CityLife Health will be entitled to directly receive all insurance payments on my/the patient's behalf. The insurance information I provided to CityLife Health is accurate. I understand that providing inaccurate insurance information may result in me receiving a patient bill. If I receive a patient bill due to inaccurate insurance information, it is my responsibility to contact CityLife Health to provide correct insurance information so my insurance can be properly billed. If I lose insurance coverage after receiving medical services that would be covered if I kept my insurance, I agree to pay CityLife Health their applicable self-pay rate(s) for the services provided to me/the patient.

By signing below, I acknowledge that I have read and understand this Consent for Treatment.

Signature of Patient/Legal Guardian: _____
Date: _____

Telephone Authorization: Authorization for the services listed in this form was obtained by telephone from the patient's proper representative, as the patient is a minor, or is not physically/mentally capable of giving the necessary authorization.

Prior to this telephone authorization, the information outlined in this form was provided by _____ on (date) _____ to the patient's representative.
Representative's name: _____
Relationship to patient: _____
Witness: _____