NKN STUDENT HEALTH & WELLNESS CENTER

24705 US-101, Rockaway Beach, OR 97136
Mailing Address: PO Box 176, Wheeler, OR 97147
Telephone: 503-355-3500 | Fax: 844-720-1901

Received by: ___________
Entered by: ___________

Nehalem Bay Health Center (formerly known as Rinehart Clinic) is the medical sponsor for NKN Student Health & Wellness Center and operates according to the guidelines set forth by Oregon Law (Oregon Revised Statutes: 109.610, 109.640, 109.675, 109.680). All services will be provided by the Nehalem Bay Health Center care team.

CONSENT TO TREAT AND AUTHORIZATION FOR RELEASE OF BILLING INFORMATION - ADULT

Please read the following completely and sign below. Services may be withheld if not signed.

I consent to health care and treatments (for myself and/or for the person for whom I am guardian) as may be deemed necessary, advisable, and ordered by the healthcare provider(s) at NKN Student Health & Wellness Center. This may include, but are not limited to laboratory procedures, x-ray examination, mental health and substance abuse services.

I hereby authorize Nehalem Bay Health Center to release to a third-party payer any medical or psychiatric condition, alcohol or drug related condition and records concerning diagnosis and treatment when requested by such a third-party for its use in determining a claim for payment for such treatment and/or diagnosis.

I agree to pay for all services provided by Nehalem Bay Health Center. I understand that I am financially responsible for the fees for the services and procedures rendered and/or any other related fees. I hereby authorize payment of medical benefits directly to Nehalem Bay Health Center herein specified and otherwise payable to me for their service(s) as described, but not to exceed the reasonable and customary charges for these services.

I permit a copy of this authorization and assignment to be used in place of the original that is on file at the healthcare provider's office. This assignment will remain in effect until revoked by me in writing.

I have read and I understand the above statement and my financial responsibilities.

PATIENT/GUARDIAN/PATIENT REPRESENTATIVE

PRINT NAME: ________________________________

SIGNATURE: _________________________________

DATE: _________________