

Informed Consent to File- Restrict Insurance Regarding EOB Sent to Policy Holder

You have informed us that you have Private Insurance and/or Medicare. Please select and sign one of the options below regarding your insurance.

I give my consent for my Private Medical Insurance, and/or Medicare to be billed for services provided by **Sample County Health Department** I understand these charges may include services for communicable disease services (TB, HIV, STD), Family Planning, Pregnancy testing and Maternity and other services if applicable. I understand that when a claim is filed that an Explanation of Benefits (EOB), which includes services rendered and diagnosis, will be sent to the insured's home address by the insurance company. I also understand that any services not covered by my insurance company are my responsibility. I further understand this consent will remain in effect a year from the date signed.

I specifically give my consent for my insurance to be billed for visits related to Substance Use that are protected under 45 C.F.R part 2.

« Signature »

Date

Patients and/or Legal Representative's Signature

Restriction to NOT bill Insurance

I do **NOT** give my consent for my Private Medical Insurance and/or Medicare to be billed. I understand that if there is a fee for these services that I will be responsible for paying the fee at the time of the visit. I understand that if I fail to do so, my insurance will be billed in order for **Sample County Health Department** to receive payment for services unless restricted by State or Federal regulations. **Sample County Health Department** will adhere to confidential contact restrictions.

« Signature »

Date

Patient and/or Legal Representative's Signature