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