PINNACLE HEALTH CARE
Taking Health Care to a Higher Level

CONDITIONS OF TREATMENT

1. Medical Consent: The undersigned consents to receive comprehensive health services and medical treatment from PHC including the provision of medical tests, procedures and treatments that are necessary or advisable for the medical evaluation and management of the patient's healthcare by any PHC healthcare professional. The undersigned acknowledges that additional specific consent may be needed prior to performing any invasive procedure or a procedure that involves risk to the patient. The undersigned agrees to inform PHC healthcare professionals of all medical history, medications and substances taken, and any changes in health. The undersigned agrees to allow PHC to provide treatment or treatment options and maintain medical records regarding the patient.

2. Release of Patient Information: Demographic information, including patient name, age, address, sex, payer status, general condition and other similar information is collected by PHC. This information is used for general business purposes of PHC as described in the PHC Notice of Privacy Practices. PHC also collects patient information of a clinical nature, including information relating to HIV, psychiatric, drug or alcohol treatment. PHC may, subject to restrictions described in the PHC Notice of Privacy Practices, disclose any information, including information relating to HIV, psychiatric, drug or alcohol treatment, for the provision of care, the advancement of medical science, education, research, the preservation of the Public health, accreditation, or in response to legal or statutory requirement(s).

3. Assignment of Insurance and Similar Benefits: In the event a patient is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, such benefits are hereby assigned to PHC for application to patient's bill. Patient is responsible for charges not covered by this assignment. The undersigned further understands that PHC does not accept all assignments and that independent arrangement may need to be made for payment for services related to this visit. Patients eligible for Medicare hereby authorize PHC to bill and collect from Medicare directly. Any charges not covered by Medicare or any supplementary insurance are the responsibility of patient. PHC may disclose all or any part of patient's record pertaining to an episode of care, including information relating to HIV testing and treatment, psychiatric, alcohol and drug treatment records, to any person or corporation which is or may be liable under contract to PHC or to patient or to a family member or employer of patient for all or part of PHC's charge including, but not limited to, PHC or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or patient's employer.

4. Financial Agreement: The undersigned agrees, whether signing as patient, parent of a minor child or legal guardian or conservator of patient, and whether or not undersigned is insured or is a member of a health maintenance organization, that in consideration of the services to be rendered to patient, undersigned is hereby obliged to pay the rates and charges PHC has on file with the Arizona Department of Health Services. Should the account be referred to collection, the undersigned shall pay reasonable collection expenses, including attorney's fees.

The undersigned has read and understands the Conditions of Treatment, accepts its terms, and has received a copy of the PHC Notice of Privacy Practices and PHC Patient Rights and Responsibilities. This condition of treatment may not be altered or amended. Any such changes will have no force or effect.

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Signature of Patient Date

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Power of Attorney or Authorized Signature Date