HealthReach

AUTHORIZATION AND AGREEMENT FOR EMERGENCY TREATMENT

The undersigned hereby makes the following Acknowledgments and Agreements regarding emergency treatment to be provided to the patient whose name appears on the reverse side hereof.

Consent for Treatment: I understand that medical treatment of an urgent nature is necessary for the patient and that such medical care treatment and procedures will be performed by independent : physicians', their physician assistants and by employees of HealthReach. I understand that only emergency treatment is being provided and that no responsibility will be taken for long-term patient care. I hereby grant my authorization and consent to such treatment and procedures and certify that no assurance has been made as to the results which may be obtained.

Selection of Personal Physician: I understand that if hospitalization or further treatment is required, HealthReach will attempt to contact the patient's personal physician to provide the service. If the patient does not have a personal physician or the personal physician cannot be contacted, the HealthReach physician may select another physician to provide this care.

Agreement to Pay for Services: For consideration of the care and treatment provided to the patient, I promise to pay all charges for services rendered to or in behalf of the patient. If payment is not made at the time of service, at our option, you the patient may be turned to a Collection Agency. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or to my family, I/we agree to pay attorney's fees and such costs as the court deems proper.

Release of Medical Information: I hereby authorize HealthReach to release any medical information in connection with these services for health insurance purposes or to the patient's personal physician.

Leaving Against Medical Advice: In the event the patient leaves against the advice of the attending physician the undersigned hereby releases the attending physician and its agents, servants or employees from any and all responsibility and any ill effects which may arise or result therein and the undersigned agrees neither to hold or attempt to hold the said attending physician or the HealthReach or its agents, servants or employees liable for resulting loss of damage.

I have read the above Acknowledgments and Agreements and fully understand the same.

Signature:_____ Date:_____

HIPAA PRIVACY PRACTICE NOTICE

I hereby acknowledge that I have read and may request a copy

of the HIPAA Notice of Privacy Practice.

Signature:_____ Date: _____

FINANCIAL POLICY

I hereby acknowledge that I have read and understand the financial policy.

Signature: _____ Date: _____

Print Patient Name:_____

2030 Bluegrass Circle Cheyenne, Wyoming 82009

(307) 635-3500