Sto-Rox Family Health Center
710 Thompson Avenue
McKees Rocks, PA 15136
Phone: (412) 771-6462
Fax: (412) 771-5887

Hilltop Community Health Center
151 Ruth Street
Pittsburgh, PA 15211
Phone: (412) 431-3520
Fax: (412) 431-3525

Consent to Treatment

I hereby authorize Sto-Rox Neighborhood Health Council (SRNHC), through its appropriate personnel, to perform or have performed upon me, or the named patient, appropriate assessment and treatment procedures. I consent to such treatment as deemed medically necessary by the attending provider. I further authorize SRNHC to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

____ ____/____/____

Print- Patient Name *Patient Date of Birth*

____ ____/____/____

Signature- Patient / Guardian of Patient *Today's Date*

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Relationship- Patient / Guardian of Patient

Financial Responsibility Statement

Sto-Rox Neighborhood Health Council (SRNHC) appreciates the confidence you have shown in choosing us as providers for your health care needs. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for deductibles, co-payments/co-insurances, and any other out of pocket expenses as determined by your insurance carrier.

I understand that by consenting to services, I agree to the fulfillment of payment. Payment is expected at the time of service; payment plans and sliding scale fees are available to everyone.

I have read the above policy regarding my financial responsibility to SRNHC for providing services. I certify that the information provided is, to the best of my knowledge, true and accurate. I also authorize direct insurance or third party payment, release of medical bill data related to claims, and permission for the provider to receive information from the pharmacy data bank.

*Print – Patient / Guarantor*______________________________*Date* ________________

*Patient / Guarantor Signature*______________________________*Date* ______________

Relationship- Patient / Guardian of Patient ____________________