Please request the following documents from the receptionist and take a moment to read them.

- I have read and agree to the *Deemed Consent for Blood Testing*
- I have read and agree to the *Patient Rights and Responsibilities*
- I have read and agree to the *Patient Consent for Treatment.*
- I have read and agree to the *Prescription Policy.*
- I agree to allow the Patrick County Department of Social Services to share their most current financial information with the CHFC and the MedAssist Program
- The documentation required for registration is my responsibility. I understand that my failure to comply with the requirements of income documentation following my first visit will be just cause for being denied medical care at this facility.

I understand that the privileges of care from this clinic come with the financial and personal responsibilities that may be required of me. I am aware that my financial information for the current year MUST BE PROVIDED before I will be seen again following this visit.

Signed _____ CHFC Witness _____

If you have any questions, please ask! We are happy to assist you!