Clinton
REGIONAL HOSPITAL
Primary Care
Dr. Nadia Azuero

PERSONAL VALUABLES

I understand that Clinton Regional Hospital does not assume responsibility for any personal items I bring into the facility.

FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

I _____ authorize direct payment to Clinton Regional
Name
Hospital of any insurance benefits. I understand that I am financially responsible for any charges not covered by my insurance. I authorize the release of any medical information necessary to process insurance claims for healthcare.

COMMUNICATION CONSENT

I _____ authorize Clinton Regional Hospital and its
Name
associated practitioners and services to contact me via:

- Phone calls to the number(s) provided, including my cellular phone
- Text messages to cellular phone number (s) provided
- Email to the email address provided
- Postal mail to my home address

For the purposes of treatment, appointment reminders, satisfaction surveys, healthcare management, and payment.

By signing this form, I _____ acknowledge that I have read and understand the contents above and have had the opportunity to ask questions and have them answered to my satisfaction.

Patient Signature: _____ **Date:**_____ **Time:**_____

Printed Name: _____

Relationship to Patient (if not self): _____

Witness Signature: _____ **Date:** _____ **Time:** _____

Witness Name: _____