Secondary Insurance Relationship to pt.

Name of

Insured Birth-date of Insured Relationship to pt. SSN of insured:

ID Number Group {f

Amount of deductible $ or Co-Pay

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. xDate

Name DOB Today's Date

<table>
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ASSIGNMENT AND RELEASE

I understand that I am financially responsible for the payment of medical charges incurred on my behalf at, Minidoka Medical Center, regardless of third party coverage. I consent to and authorize Minidoka Medical Center to furnish medical information to any third party who may be responsible for payment of all or part of my charges incurred at Minidoka Medical Center. I authorize my insurance company, or ay responsible third party to pay benefits directly to Minidoka Medical Center.

Initial Here

</td></tr>
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Consent for Photograph

I consent to allow photography of myself for identification purposes and for purposes of improving my medical care documentation (ie: wounds, lesions, etc).

Initial Here

</td></tr>
<tr><td>

AUTHORIZATION FOR TREATMENT

I hereby authorize, Minidoka Medical Center, and any assistants or associates that may be designated, to perform medical and hospital care to the above named patient

Sign here Date

</td></tr>
</table>

Consent to use of answering machine and/or voicemail messaging/email:

I hereby consent to the use of my answering machine and/or voicemail for the purpose of relaying important information regarding my treatment or care, including, but no limited to confirmation of appointments, changes in medication, results of lab tests, special instructions for testing procedures. I also consent to members of my family receiving this information in my absence. This consent will remain in effect until I rescind the consent in writing.

Signature of Patient/Patient representative Date

FOR MEDICARE PATIENTS: Medicare Authorization to receive a ments:

Medicare Identification Number:

I request that payment of authorized Medicare benefits be made either to me, or on my behalf to Minidoka Medical Center/Rural Health Clinic for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and