Great Plains Geriatrics, L.L.C.
135 Ponderosa Ave
Hill City, SD 57745
Telephone: 605-394-2118
Fax: 605-307-8999

Informed consent

1. I _____ (patient name) voluntarily consent and authorize **Great Plains Geriatrics** to provide reasonable and necessary medical examinations, testing and treatment by any clinician within the physician group.
2. I agree to allow **Great Plains Geriatrics** to file necessary insurance claims for reimbursement for the medical care and treatment that I receive.
3. I understand that:
    - **Great Plains Geriatrics** will be required to share and provide medical record information to my insurance company.
    - I agree to pay my share of the costs not covered by insurance.
    - I agree to pay the reasonable cost of such medical care or treatment not covered by my insurance carrier/policy or if not currently insured by any policy.
4. I understand:
    - I have the right to refuse any procedure or treatment at any time.
    - I have the right to discuss all medical treatments regarding purpose, potential risks and benefits of any treatment or testing with my clinician.
    - This consent will remain fully effective until it is revoked in writing. I have the right to discontinue services at any time.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Patient or Representative Relationship to Patient