



## Community Care Program Consent/Denial Form

Yes, I agree to participate in the Beaver Dam Community Hospitals, Inc. Community Care Program.

No, I do not wish to participate in the Beaver Dam Community Hospitals, Inc. Community Care Program. I will be responsible for my health care expenses.

Date: \_\_\_\_\_

Patient/Guarantor Signature: \_\_\_\_\_

Witnessed by: \_\_\_\_\_