Community Health Center

CONSENT FOR TREATMENT

I hereby give my consent for treatment of myself or _____ (name of patient) (of whom I am the parent or legal guardian) to the Community Health Center, Inc. ("CHCI") and confirm that the above information provided is correct. I understand that I am giving consent for routine treatment, or services, that are considered necessary or advisable for me, or my dependent. I understand that I am asked to participate in my, or my dependents, care plans and that I have the right to refuse interventions, treatment, care, services, or medications to the extent that the law allows. I understand that the care I, or my dependent, will receive may include tests, medications, injections, etc., that are based on established medical criteria, but not free of risk and that I will be advised of any such risks prior to agreeing to any test, medication, injection etc. Finally, I understand that CHCI sometimes has health professions trainees and students who may participate in my care or the care of my dependent. These students/trainees are under the supervision of CHC staff.

DISCLOSURE OF INFORMATION

I authorize CHCI to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to enable CHCI to obtain payment for the services it provides to me; and (3) to permit CHCI to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.
I am aware that this authorization to use and disclose information may include information regarding: (1) HIV or AIDS; (2) alcohol or drug abuse; (3) mental illness or any behavioral health condition; (4) sexually transmitted diseases; (5) family planning, pregnancy and abortion. I am aware that CHCI may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

I authorize CHCI to request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. This consent form will remain in effect until the day I revoke consent. To deny consent at any time, please speak to a Patient Services Associate, who will assist you with this opt-out process.

ASSIGNMENT OF BENEFITS

I assign to CHCI all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers and other third parties who are financially liable for the medical care and treatment provided by CHCI. I authorize the release of information required by the insurance company for billing purposes and realize that proof of insurance coverage needs to be provided in order for CHCI to file an insurance claim on my behalf. I agree that any benefits paid by my insurance carrier will be paid to CHCI. I agree to notify CHCI immediately of any changes in my insurance.

FINANCIAL OBLIGATIONS

I agree that, except as may be limited by law or CHCI's agreements with third party payers, in the event of non-payment by a third party (i.e. my insurance) for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at CHCI locations in accordance with the rates and terms of CHCI in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles. I understand should I fail to provide any requested information to my insurance company or CHCI, CHCI reserves the right to bill me for services at the full fee. CHCI also reserves the right to report delinquent accounts to credit reporting and collections agencies. I understand that I have access to CHCI's sliding fee scale discount program for charges based on my income, and I agree to notify CHCI immediately of any changes in my income. Please speak to a Patient Services Associate if you have questions about the sliding fee scale discount program.

HEALTH INFORMATION EXCHANGE

CHCI utilizes an electronic health exchange that allows us to share clinical information with other doctors, nurses, hospitals, and healthcare facilities. The program assists in providing the best possible care by allowing providers outside of CHCI to see your clinical information. This includes current and past medical, behavioral health, and dental records at CHCI. I understand that this authorization will permit CHCI to enroll me in this program. I understand that by enrolling in this program, healthcare providers and authorized personnel that participate in the electronic health exchange will be able to access my health information more effectively and accurately. I understand that if I do not want to enroll in the electronic health exchange, I must call my provider's office and request to opt-out.

CONTACT RELEASE

CHCI routinely contacts patients by phone, text (if cell phone number provided), email (if email address provided), and/or mail to remind them about appointments, inquire about bills and notify them of other CHCI programs and services. Patients or legal representatives who do not wish to be contacted by phone, text, mail and/or email, should speak to a Patient Services Associate, who will document your preferred method of communication.

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I understand that my signature below acknowledges that I have received a copy of the Notice of Privacy Practices describing how health information about me, or my dependent, may be used and disclosed. I understand that CHCI is required by law to protect my, or my dependent's, personal health information and that there are times when the law allows my, or my dependent's, personal health information to be shared with individuals or entities outside of CHCI, including but not limited to treatment, payment and health care operations purposes, when required by law, and in connection with the mandatory reporting of certain diseases. I have had the chance to ask questions about CHCI's Notice of Privacy Practices and feel comfortable with the protections that it offers me.

I certify that I have read the above information and the information that I have provided to Community Health Center, Inc. is true to the best of my knowledge. I will notify you of any changes.

Signature of Patient or Legal Guardian **Date**

Print Name of Patient or Legal Guardian **<u>If not patient or parent, proof of legal authority must be provided</u>**