Consent for Treatment and Release of Information

Child Guidance Center of Southern CT (CGC) has formed an alliance with Community Health Center, Inc. (CHC).
Your CGC providers will continue to provide your care at the same location(s).
CHC will provide billing and administrative services. Please let the front desk or your provider know of any questions.

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. ("CHC") 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 CHC 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 CHC 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 CHC to obtain payment for the services it provides to me; and (3) to permit CHC 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 CHC may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.

I authorize CHC 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 CHC 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 CHC. 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 CHC to file an insurance claim on my behalf. I agree that any benefits paid by my insurance carrier will be paid to CHC. I agree to notify CHC immediately of any changes in my insurance.

FINANCIAL OBLIGATIONS

I agree that, except as may be limited by law or CHC'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 CHC locations in accordance with the rates and terms of CHC 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 CHC, CHC reserves the right to bill me for services at the full fee. CHC also reserves the right to report delinquent accounts to credit reporting and collections agencies. I understand that I have access to CHC's sliding fee scale discount program for charges based on my income, and I agree to notify CHC 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.

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HEALTH INFORMATION EXCHANGE

CHC 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 CHC to see your clinical information. This includes current and past medical, behavioral health, and dental records at CHC. I understand that this authorization will permit CHC 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

CHC routinely contacts patients by phone, email (if email address provided), and/or mail to remind them about appointments, inquire about bills and notify them of other CHC programs and services. Patients or legal representatives that do not wish to be contacted by phone, mail and/or email, should speak to a Patient Services Associate, who will provide a special form to sign. I understand that CHC will only contact me via text message if I grant CHC permission to do so (see below).

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 CHC 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 CHC, including but not limited to treatment, payment and 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 CHC'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>**

CONSENT TO COMMUNICATE VIA TEXT MESSAGE

I agree that CHC may send me text messages for myself or my dependents.
I understand that I will have the option to opt out of receiving text messages at any time.

(If you **<u>DO NOT</u>** want to receive text messages at this time **<u>do not complete the section below</u>**.)

☐ **I wish to receive text message reminders about my healthcare.**