MID-STATE HEALTH CENTER
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midstatehealth.org

Mid-State Health Center: Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices

Patient's Printed Name _____ **DOB** _____

CONSENT TO TREAT:

I, the patient identified below or the parent or legal guardian of the patient identified below (the "Patient"), consent to receive health services from Mid-State Health Center ("MSHC"). This service may include diagnostic tests and/ or procedure(s), treatments and/ or tests that a physician, nurse practitioner(s), clinician, and other professional staff member(s) (each a "Provider") deems to be necessary and advisable in regards to my specific care plan. The name, credentials, licensure/certification, and/or qualifications of the Provider providing my care is available upon request.

I understand that services may include routine or specialized diagnostic tests and procedures up to and including diagnostic x-rays, the administration or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examinations. I understand that no guarantees have been made to me as to the results or effectiveness of treatments or examinations performed by MSHC personnel.

I understand that as part of the diagnostic process, my health condition may necessitate that the Provider obtain a photograph or image in certain situations (i.e., wound care). I consent and agree to the use of this image and acknowledge that it may be necessary when providing quality healthcare services. I understand that all or a part of the image may become part of my medical record.

I acknowledge that in cases where the Patient discloses the intent to harm to self or others, or instances of past or present child neglect or abuse, disclosure and/or mandated reporting may result in accordance with applicable local, state or federal law and/or MSHC's policies and procedures.

I authorize MSHC to retrieve and store relevant treatment history through a health information exchange as permitted by state law and to use and disclose PHI as permitted under the Health Insurance Portability and Accountability Act ("HIPAA"), HITECH, other applicable law, and by MSHC's Notice of Privacy Practices. I understand that I may choose to opt out of the health information exchange, pursuant to applicable state law.

I understand that I will have access to my medical record through MSHC's Patient Portal. I may obtain copies of such records from the Patient Portal for my own use. Alternatively, I may request a copy of my medical records by filling out an Authorization to Release Protected Health Information through the Health Information Management (HIM) department. A form is available through www.midstatehealth.org, emailing medicalrecords@midstatehealth.org or by calling (603) 536-4000.

Medical/ Behavioral Health Visits for Adolescent during School Hours

I understand that, in some instances, such as when the Patient is in school or elsewhere, that the parent or legal guardian may not be available to accompany the adolescent to an appointment. If the patient is over 16 years old and if I so choose to allow them to attend an appointment without a parent or legal guardian present, I will complete an Authorization to Treat a Minor Child Form in advance and submit to MSHC's HIM Department.

I understand that the Provider will not prescribe to the Patient any new medications or controlled substances under federal law, without consulting and getting informed consent of the parent or guardian.

I agree that MSHC will not be held responsible for any accidents, events or incidents that may occur before or after the office visit or during transportation to the Patient's appointment.

II. RELEASE OF INFORMATION: I hereby consent to the use and disclosure of the Patient's health information for purposes of treatment, payment and to facilitate MSHC's health care operations as described in the Notice of Privacy Practices. I hereby authorize and direct MSHC to release to government agencies, insurance carriers, managed care companies, or other entities who are or may be financially liable for the Patient's medical care (and to authorized agents of such entities) all information needed to substantiate payment for this medical care and to permit representatives thereof to examine and request copies of records related to the Patient's case and medical treatment. I further authorize MSHC to release billing information to any healthcare provider the Patient chooses or who may be involved in the Patient's care.

III. ASSIGNMENT: I hereby assign, transfer and set over to MSHC sufficient monies and/or benefits to which I am or may be entitled from government agencies, insurance carriers, or others who may be financially responsible for the Patient's medical care to cover costs of the care and treatment rendered.

IV. PATIENT GUARANTEE OF PAYMENT: I accept that I am financially responsible for all services rendered on the Patient's behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my or the Patient's insurance coverage (hereinafter, the "insurance plan"), plus any collection costs for amounts personally owed by me. I acknowledge that there may be services provided by MSHC that may not be covered by the insurance plan for one or more reasons, including but not limited to exclusions under the insurance plan, exhaustion of benefits, the insurance plan's designation of MSHC as an out-of-network provider, and/or my failure to provide the insurance card. I understand that if I do not fulfill the requirements of the insurance plan, do not receive the requisite prior approval, if the authorization is denied, or if the insurance plan refuses to pay the cost of the telemedicine services for any other reason, I understand and agree that I am financially responsible for the cost of these services.

If the insurance plan sends me, or the Patient, money that is designated to pay for the services provided by MSHC, I agree to promptly send the check or an amount equal to the amount received by the insurance plan to MSHC. I understand that all bills are to be paid immediately upon receipt. Should a medical bill create an unexpected financial hardship, I will contact MSHC to discuss payment arrangements. I also understand that in the event my account is transferred to a collection agency due to my failure to pay for services, that I will be responsible for any reasonable attorney's fees and costs collection fees and costs incurred by MSHC in collecting payment, in addition to the amount of the bill.

V. HIPAA ACKNOWLEDGEMENT: I understand that MSHC has a Notice of Privacy Practices that contains a description of the permissible uses and disclosures of my health information. I further understand that MSHC may update its Notice of Privacy Practices at any time, and that I may receive an updated Notice of Privacy Practices by submitting a request in writing to MSHC or by accessing the most current Notice of Privacy Practices online at www.midstatehealth.org. I acknowledge that I have received a copy of MSHC's Notice of Privacy Practices and understand that I may request a copy of this Notice in the future.

VI. AFFIRMATION: I affirm that I have read and fully understand this Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices form and have been given the opportunity to ask questions and that all my questions have been answered to my satisfaction.

_____ _____

Patient's Signature: Date:

_____ _____ _____

Legal Representative's Printed Name: Legal Representative's Signature Date:

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Authority/ Relationship of Representative to Patient