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

Patient Name: ____ **Date of Birth:** _________________________

1. Consent for Treatment

I, the patient or parent/legal guardian of the patient named above (the "patient"), agree to receive health services from Mid-State Health Center ("MSHC"). Care may be provided by staff, residents, students, and supervised trainees (the "provider"). Information about the provider's name, credentials, and qualifications is available upon request.

Health services may include routine or specialized tests and procedures, such as x-rays, the administration or injection of medications, and blood draws for laboratory examinations, determined to be necessary for my care plan. I acknowledge that no guarantees have been made to me about the results or effectiveness of treatments or examinations performed by MSHC personnel.

I acknowledge that in cases where the patient discloses the intent to harm 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.

2. Telehealth Services

I understand that some services may be provided by telehealth (phone, video, or other secure technology). Telehealth follows the same standard of care as in-person visits. There are some risks which may include technical problems or limits to physical examination. If certain medications (like controlled substances) are prescribed through telehealth, my consent will be documented as required by New Hampshire law. Emergency services cannot be provided by telehealth. I understand that I may choose in-person visits or stop telehealth services at any time.

3. Communication with Me

I understand that MSHC may communicate with me by phone calls or voicemail, text messages, secure patient portal messages, and/or limited secure email (for certain situations). I understand that these communications may include reminders, instructions, or billing information. Texts and emails may not be fully secure, but the center will take reasonable steps to protect my privacy. I can opt out at any time.

4. Use of AI Scribe Technology

I understand that providers may use an AI-powered transcription or scribe tool to help document my visit. This tool listens during the visit and creates a medical note. My provider reviews, edits, and approves all notes for accuracy. The information is protected under HIPAA. No recordings are kept once the note is completed. I am aware I may opt out of the use of AI scribe technology at any time.

5. Photos/Video for Care Purposes

I understand that my health condition may require MSHC to obtain a photograph or image in certain situations (i.e., wound care). I agree to the use of this image and acknowledge that it may be necessary when providing quality healthcare services. I understand that the image will become part of my medical record. These will not be used for marketing or external purposes without my separate written permission.

6. Privacy and Information Sharing

I acknowledge that Mid-State Health Center (MSHC) can use and share my health information for the purpose of treatment, payment, and health care operations as allowed by law and explained in the Notice of Privacy Practices. MSHC may update this Notice at any time. I may request a copy in person or by writing to MSHC or view the latest version online at www.midstatehealth.org.

MSHC may access and store my treatment history through a secure health information exchange as permitted by law. I understand I can choose to opt out, following state rules.

I understand I may access my medical records through MSHC's Patient Portal and download copies for my own use. If I need official copies, I can request them by completing an Authorization to Release Protected Health Information form. This form is available at www.midstatehealth.org, by emailing medicalrecords@midstatehealth.org, or by calling (603) 536-4000.

I authorize MSHC to share my health information with government agencies, insurance companies, managed care organizations, or others responsible for paying for my care. These groups may review and request copies of records related to my treatment.

7. Fundraising Contact

The health center may contact me about fundraising to support its mission. Only PHI as allowed under the Health Insurance Portability and Accountability Act ("HIPAA"), HITECH, other applicable law, and by MSHC's Notice of Privacy Practices will be used for fundraising purposes. My diagnosis, treatment, or financial information will NOT be used for fundraising without my separate written permission. I can opt out of fundraising communications at any time.

8. Guarantee of Payment

I accept that I am financially responsible for all services given on my or the patient's behalf. I accept personal responsibility for all co-payments, deductibles, and non-covered services, plus any collection costs due to non-payment of amounts owed by me or the patient in addition to the amount of the bill. I acknowledge that there may be services provided by MSHC that may not be covered by my 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. 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.

I hereby assign 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 received. 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.

9. Patient Rights and Responsibilities

I understand that MSHC has a Patient Bill of Rights that explains my rights and responsibilities as a patient. I further understand that MSHC may update its Patient Bill of Rights at any time, and that I may receive an updated copy upon request, by submitting a request in writing to MSHC, or by accessing the most current Patient Bill of Rights online at www.midstatehealth.org.

10. Affirmation

I affirm that I have read, fully understand, and agree to the information included in this document and have been given the opportunity to ask questions and that all my questions have been answered to my satisfaction.

Patient/Parent/Guardian Name (Print): ____

Signature: ____ Date: __________