Sixteenth Street
COMMUNITY HEALTH CENTER

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT& HEALTHCARE OPERATIONS FORM

Sixteenth Street Community Health Center is dedicated to providing primary medical care, behavioral health services and essential supportive services with a multi-disciplinary approach to care. Because physical and emotional problems often go together, we believe that the best care is given when healthcare providers work together. SSCHC patients may be referred to other health care specialties and case management within the SSHCC treatment team.

I understand that if I am 14 years of age or older, I must consent to behavioral health services: If I am 18 years or older, I may consent for all other health services. By signing this section of the form I agree that I have read or have had the form explained to me, that I understand it and that any questions I asked have been answered.

I understand that if I engage in behavioral health services, my diagnosis, medications and status of care may be shared as part of an integrated record with my primary physician, physician assistant, or midwife if housed at SSCHC. I understand that no other clinical information will be shared without my expressed written consent.

I understand that I have the right to refuse treatment at any time and that an explanation of risks and benefits of treatment are an expected part of my care.

I agree to receive medical care, behavioral health care, case management, diagnostic procedures and/or other treatments to be rendered by the appropriate personnel at Sixteenth Street Community Health Center as requested, delegated or directed by Sixteenth Street Providers.

_____ Date _____

Signature of Patient or Personal Representative

I, Name of Parent/Guardian, as a legally authorized representative of Name of Patient
do give consent for the patient named above to receive medical care, behavioral health care, diagnostic procedures and treatments to be rendered by the appropriate personnel at Sixteenth Street Community Health Center as requested, delegated or directed by Sixteenth Street Providers

_____ Date _____

Signature of Patient or Personal Representative/Relationship

The SSCHC's Notice of Privacy Practices has been provided to me and is publically posted. I understand I have a right to review SSCHC's Notice or Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the SSCHC. The Notice of Privacy Practices for SSCHC is also provided at the front lobby.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, member of social services/health education team, a health plan or my employer. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that this protected health information may be disclosed without my permission if 1) I am a threat to myself or others 2) I am unable to protect myself from risk of harm 3) I am in the legal custody of a government agency or facility 4) There is evidence of child abuse 5) My clinical records are requested under court order 6) To collection agency for overdue accounts. I consent to the use or disclosure of my (or person named above medical and behavioral health information by Sixteenth Street Community Health Center (SSCHC) to other healthcare providers for the purpose of diagnosing or providing treatment, and to others for the purpose of obtaining payment for my health care bills or to conduct health care operations of SSCHC.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, social services or health education operations of the practice. SSCHC is not required to agree to the restrictions that I may request. However, if SSCHC agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that SSCHC has taken action in reliance on this consent. I have been given information about SSCHC's participation with Health Information Exchanges that supports the flow of health information among physician practices, hospitals, labs, and others. That information shows me how to "opt out".

I give my consent for SSCHC to confirm my appointments and to inform me of follow-up care via an email, telephone or text message to the number I have given. I understand that specific medical information will not be left on messages and results may not be discussed on the telephone due to the difficulty of confirming identity. I know that this is not a requirement for care here and that I may revoke this permission at any time. I know that my private PIN allows access to my chart via My Health Connect and that I am responsible to safeguard that PIN.

I understand that I am responsible for all charges, deductibles and co-pays whether or not they are covered by my insurance.

I understand that I will face dismissal from care if I miss more than 5 appointments in a 12 month period, without proper advanced notice.

_____ _____

Signature of Patient or Personal Representative/Relationship Date

_____ _____

Signature of Witness Date

Rev 10/14