General Patient Consent

Patient Name:_____ **Date of Birth**:_____

In an effort to assist us in collecting information for your care and to provide you with an understanding of our request, please carefully read each section below. It is important that you understand the information provided. If you have any questions, do not hesitate to ask us for assistance. If you do not agree with an area below, cross out that section and place your initials and the date beside that section.

CONSENT FOR MEDICAL TREATMENT: I agree to allow this provider to conduct procedures to diagnose a medical concern, provide medical care, and provide treatment and/or emergency treatment ordered by my provider which are necessary. I realize that the provider(s) attending to me directs my care and is responsible for telling me about the type of care and treatment I will receive. No promises have been made to me as to the results of examinations or treatments provided to me. I understand that students and clinical assistants in the medical field under appropriate supervision may watch or help with my care; however, I have the right to refuse such treatment at any time.

CONSENT FOR COORDINATION OF CARE BY COMMUNITY BASED ORGANIZATIONS:

I agree to allow this provider organization to coordinate my care with Community Based Organizations (CBOs) that provide services throughout the community that may meet my healthcare needs. I realize that there are instances where I may need these social services as part of my treatment and care. I have the right to refuse the coordination of social services at any time.

ASSIGNMENT OF BENEFITS:

I assign and authorize payment directly to this provider organization, and to the other providers providing services to me, or any benefits, including any and all major medical or other insurance benefits, otherwise payable to me by any third party. I authorize the clinic to contact and communicate with such third party on my behalf and to provide notice of this assignment.

PAYMENT OF SERVICES:

I understand that I am financially responsible for any insurance deductibles, coinsurance, for charges as indicated in my coverage or plan criteria, or if I am paid and the clinic does not receive the payment. In the event I do receive any benefits directly, I will immediately pay those benefits to clinic. In the event I fail to pay, I further agree to pay all costs of collection, including reasonable attorney's fees that may occur.

INSPECTION OF HEALTH CARE RECORDS:

I understand that if I need to review or obtain a copy of my healthcare records, that I may complete an access request form available at this location. This form will allow me or a person that I authorize to obtain my health care records.

General Patient Consent

Patient Name:_____ **Date of Birth:**_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

I understand that my personal health information may be used and disclosed to allow for treatment, payment, and operations as described in the Notice of Privacy Practices which I have received.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY:

I understand and allow this provider organization to obtain the external prescription history from any pharmacy or drug monitoring agency for purposes of my medical care. I understand that any pharmacy information that is received will not condition treatment, payment, enrollment, or my eligibility for benefits on my agreement or refusal to provide this approval.

CONSENT TO TELEPHONE CALLS (including Cell Phone), EMAILS, TEXTS: I understand that by providing a telephone number or email address, I am giving the provider organization permission to contact me (including autodialed calls and pre- recorded messages). I understand I may receive calls, email and text message communication regarding services or activities conducted on behalf of the provider organization through the organization's affiliates, agents, and independent contractors. I also understand that I may request to not be contacted. If applicable, data charges and rates from my cellular carrier may apply.

ADVANCE DIRECTIVES:

I agree that I have received, or have had the opportunity to receive, information regarding Advance Directives including information on how to process my Advance Directive.

NOTICE OF PRIVACY PRACTICES:

I agree that I have received, or have had the opportunity to receive, the Notice of Privacy Practices for this organization. This Notice describes how my health information is used and shared. I understand this organization has the right to change this Notice at any time and if a change is made, I will be provided with a new Notice. I may obtain a current copy by contacting this provider organization.

SENSITIVE INFORMATION:

I understand that the type of information that may be released under this agreement, unless I have requested restrictions in writing, may include treatment records for any services I receive for mental illness, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) infection, developmental disabilities, alcoholism, or drug dependence during my period of care and treatment. A form to request restriction of this type of information is available at this location.

CenterWell

General Patient Consent

Patient Name:_____ **Date of Birth:**_____

ROUTINE RELEASES OF YOUR INFORMATION AS OUTLINED IN YOUR NOTICE OF PRIVACY PRACTICES MAY INCLUDE:

- **PAYMENT**
  I allow for the release of my medical records to third party organizations such as Medicare and Medicaid or funding sources that requires that information as a condition of payment for clinic charges.

- **WORKERS COMPENSATION**
  If I am being treated for a work related injury or condition, I approve of release of health information to my employer, worker's compensation insurer, or their representative, to include copies of my medical records that are related to the injury or condition for which I am claiming compensation.

- **CARE AND TREATMENT**
  I allow the release of information (verbal and/or written) about my condition to my primary care provider or to any specialist I am referred to by my primary care provider for the purpose of continued care.

- **FOR INSURANCE PAYMENT**
  If I am a member of a health insurance plan, which requires approval for payment of my medical care and treatment, the information released about me shall also include the diagnosis and treatment plan and status of my condition. The information may be provided in written or verbal form for purposes of determining need for additional medical care.

- **MANDATORY REPORTING:**
  I understand that this provider is required by law to report findings including but not limited to suspected abuse, communicable diseases and conditions, and/or vaccination administration. I understand my health information may be submitted as required by law if it falls into any mandatory reporting categories.

General Patient Consent

I confirm that I have read the above information and my signature represents my approval of this document or I authorize the completion of this document to a representative on my behalf. I have been offered the opportunity to decline any portion of this document with which I do not agree.

Signature of Patient	**Date**	**Time**

If patient is a minor or unable to sign:

Signature of Legal Representative	**Date**	**Time**

General Patient Consent

Important! _____

At CenterWell Senior Primary Care, it is important you are treated fairly.

CenterWell Senior Primary Care (CenterWell) does not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. CenterWell complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by CenterWell, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-2188** or if you use a **TTY**, call **711**.

- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-2188 (TTY: 711)

CenterWell provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-2188 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어(Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)

برای دریافت خدمات رایگان زبانی بصورت رایگان با شماره فوق تماس بگیرید. **Diné Bizaad**

ËNavajoħ: W0dah7 b44sh bee hani'7 bee wolta'7g77 bich'9' h0d77lnih 47 bee t'11 jiik'eh saad bee 1k1'1n7da'1wo'd66 nik1'adoowo[.

العربية (Arabic)

الرجاء االتصال بالرقم المبين أعاله للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220