WHITE MOUNTAIN COMMUNITY HEALTH CENTER

Whole Person. Whole Family. Whole Valley.

Patient Name: _____

GENERAL CONSENT AND ACKNOWLEDGEMENT FORM

1. General Consent to Treatment: By signing below, I authorize the health care providers at White Mountain Community Health Center (WMCHC), to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care, services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recuperation, the likelihood of achieving goals, reasonable alternatives, and the relevant risks, benefits, and side effects related to alternatives, including the possible results of not choosing to undergo the recommended treatment.

a. Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my treating health care provider(s).

b. Medical Education and Participation of Students and Trainees: I understand that WMCHC is dedicated to medical education, and that authorized, appropriately supervised students and trainees may observe and assist in my diagnosis, treatment and care, unless I expressly object to their participation in my health care.

2. Acknowledgment of Responsibility for Payment and/or Assignment of Benefits: By signing below, I understand and acknowledge that I am financially responsible for paying all costs associated with the health care services I receive from WMCHC. I understand that I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance, including deductibles and co-payments. I understand that health information about me, including (if applicable) information related to HIV/AIDS, substance abuse, and mental health treatment, may be shared with my health insurance carrier(s) or other third party payers responsible for paying for my health care. I understand that I may choose to pay privately in full for particular services if I do not wish certain sensitive health information to be disclosed to my third party payer.

By signing below, I authorize WMCHC to share this information, including specially protected information such as mental health, substance abuse and/or HIV/AIDS information about me, with health insurers in order to be paid for the services they have provided. I agree that the patient named in this form (myself or another over whom I have legal authority) is covered by the insurer(s) that I have shared with WMCHC and that I have received no notice of discontinuation of benefits. I authorize such health insurers or other third party payers including

Medicare, Medicaid and TRICARE, pay the costs associated with my health care directly to WMCHC or its contracted agents.

3. Minors: If you are a minor who consents to health care services on your own behalf, but utilize your parent's or guardian's insurance policy to pay for your services, please know that your parent or guardian may receive an Explanation of Benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. Please speak with our staff if you wish to pay for your services in another manner and initial here: _____

4. Notice of Privacy Practices: I understand and acknowledge that WMCHC is obligated to keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, or for the internal operations of the Practice such as improving care and treatment services. I understand that a detailed list of permissible uses and disclosures is included in WMCHC's Notice of Privacy Practices.

By signing below, I acknowledge that I have been offered the Notice of Privacy Practice. I have (check box that applies):

□ ACCEPTED □ REFUSED

A copy of WMCHC's Notice of Privacy Practices

5. Signature

By signing below, I acknowledge that I have read the above information, and that

- I understand and agree to the above statements
- I have been given the opportunity to have my questions about this form answered
- I have been given the opportunity to have my questions about the Notice of Privacy Practices answered
- I understand that this document is valid for one year or until updated, whichever comes first

_____

Signature of Patient or Legally Authorized Representative Date

If signed by Authorized Representative, please state legal authority to act on behalf of patient, e.g. healthcare power of attorney, healthcare surrogate, guardian, parent of a minor, etc.

Authority: _____ Date: _____