Patient Acknowledgement and Consent Form

Release of Medical Information:
I authorize my care team to leave health information such as test results, medication information, and/or answers to my question on my answering system.

Communication Consent:
I consent to receive all forms of communication from my care team. CHC may call, text, email, or mail me important information such as appointment reminders, test results, treatment options, or health education services or events. I understand I can choose to opt out at any time.

Consent to Care:
I consent to the plan of care proposed by my care team. I understand that I, or my authorized representative, have the right to decide to accept or refuse this plan. I will ask questions as needed and will make my wishes known.

Notification of Release for Payment:
I understand that CHC will provide any diagnosis and information required to assure payment from insurance companies and any liable third-party payers. I understand that, unless expressly limited by me in writing, this may include all aspects of treatment including testing and/or treatment for HIV/Aids, sexually transmitted diseases, substance abuse or mental health conditions.

Financial Agreement:
I understand co-payments are due at the time of service. I assign payment from my insurance directly to CHC.
I understand I am financially responsible to CHC for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills from the laboratory, radiology and other specialized services.

Receipt of Notice of Health Information Practices:
I have been offered a copy of CHC Privacy Practices informing me of my rights related to the protection of my health information. I have also been offered a copy of the No Show Policy, informing me of the importance of keeping my appointments and the consequences if I do not cancel when I am unable to make it.

Patient Rights and Responsibilities:
I have been offered a copy of CHC's Patient Rights and Responsibilities, which provides me with information about being a patient at CHC.

Telehealth Care
I understand that telehealth visits are billable and that CHC will follow all patient privacy laws. If an in-person visit is required, I will be notified. I understand that if the electronic connection is lost, which may cause issues with privacy, my care team will call me back at the number that I have provided.

By signing below, you agree to all of the information above.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if patient is a minor)