Consent to Treat/Bill & Privacy Information Form

Thank you for choosing Southside Community Health Services. Please review the form below so we can provide the optimal care for you, bill appropriately, and share your information securely.

CONSENT FOR TREATMENT

By signing this form, I consent to and authorize my provider(s) at Southside Community Health Services (SCHS) to treat me or my dependent. I understand this could include lab tests, x-rays, immunizations, medication prescription and/or administration, education, other diagnostic tests, or behavioral health interventions. I understand that my provider is available to explain the treatment and I have the right to refuse treatment. I understand that this consent will be valid and remain in effect as long as I attend any of the clinics at SCHS.

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize SCHS to release any information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical, dental, and/or behavioral health information to my insurers as necessary for determination and payment of benefits; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.

NOTIFICATION OF PRIVACY

SCHS complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have received the SCHS Notice of Privacy Practices and Minnesota Patients' Bill of Rights.

CONSENT TO BILL, ASSIGNMENT OF BENEFITS, AND PAYMENT

I authorize SCHS to file a claim with my insurance carrier for services rendered. I authorize SCHS payment of benefits directly to SCHS, for services provided to my dependent or me. I understand that I am responsible for any part of the charges that are not covered/paid by my insurance and I will be billed directly for those services.

** If you are uninsured, please note that your account is your responsibility. No patient will be denied services due to his/her inability to pay. Discounts for essential services are offered dependent on income and household size as compared to the current federal poverty guidelines. Please inquire for more details. The parent or legal guardian of a minor patient (under 18 years of age) is responsible for payment on the minor's account.**

ACKNOWLEDGEMENT OF PERSONAL PROPERTY

I understand that SCHS shall not be liable for loss or damages of any personal property.

HEALTH INFORMATION EXCHANGES

SCHS endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also

enables emergency medical personnel and other providers who participate in an HIE including but not limited to EPIC CARE EVERYWHERE and who are treating you, to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. Currently, only our Medical, Behavioral Health, and Vision Clinics are able to share actual patient medical record data via HIE.

SCHS endorses supports and participates in the Minnesota Immunization Information Connection (MIIC). MIIC is a statewide immunization information system that stores electronic immunization records. MIIC combines immunizations a person has received into a single record, even if the vaccines were given by different health care providers in the state. You always have the option to limit access or opt-out of having your or your child's immunization record in MIIC. If you choose to limit your or your child's participation in MIIC you may do so at any time. Additional information regarding opting out is available by calling the MN Department of Health MIIC Help Desk at 651-201-5207 or online http://www.health.state.mn.us/divs/idepc/immunize/registry/dataprivacy.html.

BENEFITS/RISKS OF BEHAVIORAL HEALTH TREATMENT

Potential benefits include better relationship, solutions to specific problems, improved understanding of yourself, and relief from unpleasant emotions. There may be some risks including, but not limited to addressing painful emotional experiences, being challenged or confronted on a particular issue, or being inconvenienced due to costs of services.

MENTAL HEALTH CRISIS/EMERGENCY

If you have a mental health crisis or need to speak to someone, please call Suicide Prevent Lifeline at 800-273-TALK (8255) at any time, or call 911, or go to your nearest hospital emergency department; they are there to help you.

LIMITS OF CONFIDENTIALITY

We are permitted or required, under specific circumstances, to use or disclose protected health information without your written authorization: suicidal urges (being a danger to yourself), homicidal urges (being a danger to others), court order/subpoena, child abuse/neglect, and elder or vulnerable adult abuse/neglect.

TELEHEALTH CONSULTATIONS

1. The consulting health care provider or specialist will be at a different location from me. I will connect to the virtual visit from home.
2. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, and the clinician or specialist. I will give my verbal permission prior to the entry of the additional personnel.
3. The provider will keep a record of the consultation in my medical record.
4. RELEASE OF INFORMATION: (SCHS) and/or providers who provide professional services to the patient are authorized to furnish medical information from my medical record to the referring physician, if any, and to any insurance company or third party payer for the purpose of obtaining payment of the account. (SCHS) is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.
5. I voluntarily consent to health care services provided by my doctor(s) or a designee, which may include diagnostic tests, drugs, and examinations.

6. I understand that I have the option to refuse telehealth service at any time without affecting the right to future care or treatment and without risk losing benefits. I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons.
7. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.
8. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that I may revoke this consent in writing; however, my revocation will not apply to information already used or released in reliance on this consent. I agree that a copy of this consent may be used in place of the original. I also understand that by refusing to sign this consent or revoking this consent, this organization may not be able to provide services to me.

My signature below indicates that I understand and accept the content of this form.

Signature _____ Date _____

Patient or Patient Representative (print name)_____

If not the patient: Relationship to Patient: _____

Site Location_____