Clinch River Health Services

GENERAL and TELEHEALTH CONSENT FOR TREATMENT

NAME: ______________________________ **DOB:** ________________ **SSN:**________________________

1.CONSENT TO FILE INSURANCE/CORRECT INFORMATION: I authorize the release of all medical information necessary to process my insurance claims. I permit a copy of the authorization to use in place of the original. I authorize Clinch River Health Services to file my insurance for services rendered. I request that payments be made directly to Clinch River Health Services, Inc. I certify that the information that I have reported about my insurance coverage and my personal information is correct. I understand that I am responsible for all balances that my insurance company does not pay. I understand that claims may be filed electronically through a safety net internet portal. **INITIALS:**_____________

2. HIPAA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received and read the CLINCH RIVER HEALTH SERVICES HIPAA Notice of Privacy Practices. **INITIALS:** _____________

3. PATIENT RIGHTS AND RESPONSIBILITIES: I have received a copy of the patient rights and responsibilities. **INITIALS:** _____________

4. CONSENT FOR TREATMENT: I, ________________________________, give my consent for the medical staff of Clinch River Health Services, INC. to perform emergency medical treatment, acute or chronic medical treatment, preventive healthcare, behavioral/mental healthcare, and health maintenance care as deemed medically necessary. **INITIALS:** _____________

5.TREATMENT: We may use and disclose protected health information (PHI) (including alcohol and drug abuse diagnoses protected by Title 42 of CFR) about you to provide, coordinate, and manage your treatment and related services. This includes the coordination or management of your health care with CRHS staff or a third party for treatment purposes. This also includes releasing PHI where required by law. Records may be reviewed by state or federal licensure, funding, and other regulatory authorities as authorized by state and federal law and related regulations. **INITIALS:** _____________

6. DEEMED CONSENT FOR BLOOD TESTING: I understand that under Virginia Law, if a health care provider, a person employed by, under the direction of, or control of a healthcare provider is directly exposed to bodily fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patients will be deemed to have consented to testing for HIV or Hepatitis B or C and the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) A patient who tests positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling. **INITIALS:** _____________

7. INTEROPERABILITY CONSENT: Providing us access to your Electronic Health Record (EHR) from participating hospital systems and other care center(s) allows us to better serve you by being able to access important health information. Examples: Allergies, Lab Reports, ETC. By initially below, I give CLINCH RIVER HEALTH SERVICES permission to access your EHR information from other entities, including but not limited to hospitals and other care facilities. **INITIALS:** _____________

8. RX HISTORY CONSENT: Providing us access to your Medication History from pharmacies allows us to document the list of your current medications, assess drug-to-drug/drug-to-allergy interactions and obtain insurance coverage information for your prescriptions quickly and efficiently. By initialing below, I give CLINCH RIVER HEALTH SERVICES permission to access my Medication History from external databases (like Pharmacies) to better process medications. **INITIALS:**_____________

9. TELEHEALTH SERVICE if offered: I, ____________________________________, agree to receive audiovisual medical/behavioral services. I understand that the health care provider is located at **CLINCH RIVER HEALTH SERVICES 17285 VETERANS MEMORIAL HWY DUNGANNON, VA** while I am located at a different location. I also understand that:

- I can decline the Telehealth Service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled to cannot be taken away
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth Service.
- I will have access to all medical information resulting from the Telehealth Service as provided by law.
- The information from the Telehealth Service cannot be released to researchers or anyone else without my additional written consent.
- I will be informed of all the people who will be present at all sites during my Telehealth Service.
- I may exclude anyone from any site during my Telehealth Service.
- I also understand that my insurance will be billed for this visit and that I may be billed for what my insurance does not cover. I understand that if I have any questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third-party payor.

PATIENT SIGNATURE: ____ **DATE:** ________________

PARENT/GUARDIAN SIGNATURE:___________________________________ **DATE:** ________________

WITNESS SIGNATURE: ____ **DATE:** ________________

(THIS CONSENT FORM WILL BE USED AS NEEDED. YOU MAY REVOKE OR CHANGE AT ANYTIME.)

Clinch River Health Services

Patient Preferences for Receiving Communication

PATIENT NAME: ______________________________________ DATE OF BIRTH: _______________________

Please contact me as follows: [ ] Home [ ] Cell [ ] Work [ ] Other Number: ____________________

You may choose any that apply:

[ ] Leave message with appt. date, time & place
[ ] Leave message with call-back number only
[ ] Do not leave message
[ ] Written Communication
[ ] Mail to: [ ] Home [ ] Work [ ] Other Mailing address: _____________________________________

You have my permission to discuss my care with:

Name:_________________________________ Relationship: _______________ Phone: ____________
Name:_________________________________ Relationship: _______________ Phone: ____________
Name:_________________________________ Relationship: _______________ Phone: ____________

You have my permission to discuss my account balance and billing with:

Name:_________________________________ Relationship: _______________ Phone: ____________
Name:_________________________________ Relationship: _______________ Phone: ____________
Name:_________________________________ Relationship: _______________ Phone: ____________

____ _________________

Patient/Legal Guardian Signature Date

____ __________________

Witness Signature Date