



Date	
EMR#	
Location	

Declaration of Income & Consent

I affirm that all income, insurance, and payor information provided to District Health Department #10 is accurate and current. I further declare that I have read and understand all the content regarding consents below.

CONSENT FOR CARE

I consent to become a client or consent to my minor child to become a client of the District Health Department #10 (DHD#10). I understand that DHD#10 has a variety of programs for which I may be eligible, and that some of these programs have their own specific consent forms. I acknowledge that I am advised to remain in the clinic for fifteen minutes following treatment for observation of a possible adverse reaction to medications. I do not hold this agency nor its agents responsible in the event of an adverse medication reaction.

I understand that services offered by DHD#10, are confidential and that my information will not be disclosed without my consent, except when required by law. General information may be used for statistical purposes only. I understand that DHD#10 maintains an electronic record of the care and services I receive at DHD#10, as well as at any of its divisions, departments, or partner companies. My records from each DHD#10 program may be combined. DHD#10 needs this record to provide me with the best care possible and to comply with certain legal requirements.

DHD#10 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. DHD#10 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

DHD#10:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters or visual aids
- Provides free language services to people whose primary language is not English, such as
- Qualified interpreters
- Information written in other languages

I understand that my Electronic Medical Records can be accessed by all DHD#10 providers.

I further understand that DHD#10, from time to time, contracts with third-party health care providers to provide the most complete services to its clients. These health care providers may have access to my DHD#10 medical records, to the minimal extent necessary to provide services to me at DHD#10.

CONSENT TO RELEASE MEDICAL RECORDS AND INFORMATION TO INDIVIDUALS INVOLVED IN MY CARE OR PAYMENT FOR MY CARE

I authorize DHD#10 and its employees to release information from my financial or medical records to any person, organization, employer (if work-related injury), or review agency which is legally or contractually responsible or which DHD#10 reasonably thinks may be responsible for payment of my bills for my medical care. I further authorize DHD#10 to release information from my medical records to auditors and consultants who are advising DHD#10 on third party payor billing issues and/or assisting DHD#10 in preparing financial data and related documents. I understand that DHD#10 will maintain the confidentiality of my medical records, but I also understand that DHD#10 is not responsible for any breaches of confidentiality of my medical records caused by other parties. This permission includes information that may be related to drug or alcohol abuse, psychiatric care, HIV testing, AIDS (Acquired Immunodeficiency Syndrome), HIV infection or ARC (AIDS related complex) and includes social work/client communication and psychologist/client communications.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I authorize DHD#10 to bill all insurance payors and hereby assign to DHD#10 all my insurance and managed care benefits due to me for services rendered to me by DHD#10. I request that payment of the authorized benefits from those sources be made on my behalf to DHD#10 and authorize my insurance company and/or my managed care company to make payment directly to DHD#10. I understand that DHD#10 submits claims to insurance carriers as a courtesy to patients and that I am responsible for the balance owed unless DHD#10 has agreed with the payor not to balance bill. I agree to pay for all services rendered to me without regard to any benefit limitations imposed by any third-party payor, unless other arrangements are made in advance, to pay my account in full upon discharge from DHD#10; to pay any legal fees and interest at the legal rate, which result due to my not paying my balance. I understand that DHD#10 accepts no liability for failure to meet any pre-cost certification required by my insurance carrier, and I agree that I have, or will, properly execute such certification.

CONSENT TO OBTAIN INFORMATION/RECORDS

I authorize DHD#10 to obtain my information or records to or from hospital, health care providers, insurance companies, service agencies, auditors, or others involved in my care that may be pertinent to the delivery, coordination, and evaluation of my care. This includes all information about my status related to any medical condition(s), including HIV infection. I understand that such records and information include those that identify my name.

CONSENT RELATED TO PRIVACY NOTICE (ALSO KNOWN AS HIPAA)

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to inform you of your rights for privacy with respect to your health care information.

I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change, and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

AFFIRMATION & SIGNATURE

I have read this consent form or have had it read to me. I have been able to ask questions and have been given answers to my questions. I also understand that a copy of this consent form can be given to me if I request a copy.

My signature is sign of consent.

<i>Patient/Parent-Guardian Signature</i>
<i>Date</i>
<i>Patient Name (please print)</i>
<i>Guardian Name (please print)</i>

<i>Interviewer Signature</i>
<i>Date</i>
<i>Interviewer Name</i>

<i>Interpreter Signature</i>
<i>Date</i>
<i>Interpreter Name</i>