Tillamook County Community Health Centers

MRN: _____

Authorization for Treatment, Financial, HIPAA, Reproductive Health, & Patient Centered Primary Care Home Consent

_____ _____

Patient Name *Patient Date of Birth (DOB)*

Treatment and Financial

I hereby authorize Tillamook County Community Health Centers (TCCHC) to provide general medical, dental, and surgical health care as indicated by the physicians, dentists, nurse practitioners, and physician assistants of the clinic. I also authorize treatment by other health professionals, including contracted providers such as, dentists and behavioral health therapists, and those in training under the supervision of a physician.

I hereby authorize Tillamook County Community Health Centers to bill my insurance, including Medicare/Medicaid, for services received by me/the patient. I authorize my insurance carrier to pay directly to TCCHC. I understand that if any insurance I have provided to TCCHC is found to be false, I become financially responsible for the full amount of my bill. I understand I am financially responsible for co-pays. In addition, I hereby authorize the release of all applicable medical information required to secure such payments.

Acknowledgment of HIPAA Notice

I acknowledge receipt of Tillamook County Community Health Centers Notice of Privacy Practices.

Acknowledgment of Patient Rights & Responsibilities

I acknowledge receipt of Tillamook County Community Health Centers Patient Rights and Responsibilities notice.

Patient Centered Primary Care Home Consent

Your primary care home will better coordinate your care to help get you the services you need. They will listen to your concerns, answer your questions, offer after-hours help and alternatives to the emergency room, and help you play an active role in your health. I have read and understand the information in Patient Centered Primary Care Home Consent and consent to be a part of the Tillamook County Community Health Centers.

Reproductive Health Services

When seeking reproductive health services from Tillamook County Community Health Centers, I understand that I am receiving these services voluntarily.

I understand that these services may include:

- Reproductive health counseling on birth control, getting pregnant, healthy pregnancies, and other subjects as needed;
- Providing a birth control method;
- A provider visit for a prescription and possibly a physical exam;
- Testing and/or treatment for sexually transmitted infections (STIs);
- Testing for cervical cancer, pregnancy, and/or other health problems; and
- Referrals to other services, if needed.

(Turn page over to finish reading and sign this consent form)

MRN: _____

AUTHORIZATION FOR TREATMENT, FINANCIAL, HIPAA, REPRODUCTIVE HEALTH, & PATIENT CENTERED PRIMARY CARE HOME CONSENT

I understand that all services will be explained, and I can ask questions.
I understand I may be given information about birth control methods. I can ask questions and refuse any birth control method I do not want to use.

COMPREHENSIVE HEALTH SERVICES

I understand that I won't be refused care if I owe money from other visits.

I understand these services do not include 24-hour care, and in case of a medical emergency, I will need to go to an emergency room and pay its costs.

I understand that the services I receive and my medical records are private, except:

- If a judge issues a subpoena for my records, Tillamook County Community Health Centers is required by law to give the records to the court.
- If I have a reportable disease, Tillamook County Community Health Centers will be required to report it to Oregon State Public Health.
- If Tillamook County Community Health Centers staff learns of physical and/or sexual abuse of an elderly person or person under 18 years old, they must report it to social services and law enforcement agencies. Tillamook County Community Health Centers medical staff are mandatory reporters.
- I understand I may choose not to talk about sensitive information, such as the age(s) of sexual partner(s), and that I will still get services.

I understand that if I get reproductive health services here, I can still apply for or get services from other programs. If I get care from other programs, I can still get services at Tillamook County Community Health Centers.

I give my consent for Tillamook County Community Health Centers to take a face-only photo of myself or my child to use for identity confirmation purposes in our individual charts.

I hereby give my consent for the staff and/or other health professionals of the Tillamook County Community Health Centers to call and leave a message (unless otherwise further restrictions requested) either:

- With a person;
- Answering machine; or
- Voice mail at my home, work, or message number to remind me of an appointment or to reschedule an appointment.

My signature below acknowledges my receipt and consent to the above consents and services.

_____

Patient Signature **Date**

_____

Signature of Patient's Representative *(if patient is under age of consent)*

_____

Relationship of Representative to Patient