Siletz Community Health Clinic

General Patient Consent

Consent for Evaluation and Treatment

Initials

To the Patient: Welcome to the Siletz Community Health Clinic. At this point in your care, no specific treatment plan has been recommended. This consent form is an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified conditions(s). You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure(s) to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By initialing on the side, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. (3) you understand that you may be asked to sign a separate informed consent form for certain vaccines, lab tests, treatment(s) or procedures that require such. (4) you understand that consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Consent to Bill Insurance and Collect Payment

Initials

I have received a copy of the SCHC Payment Policy, attached to this form. I hereby authorize the SCHC to furnish information to insurance carriers concerning my conditions and treatments, and I hereby assign the healthcare provider(s) all payments for services rendered to my dependents or myself. I authorize SCHC to collect payments from third party payors such as Medicare/Medicaid and insurance companies. I have read and have had the opportunity to have my questions explained to me regarding my rights and responsibilities and payment policy under this agreement. My signature indicates that I consent to receiving services from the Clinic Staff at this time.

I acknowledge my responsibility to pay for care according to the fees established.

In the event that the patient is a minor, I am the parent and/or guardian of said patient and I agree that I am responsible for all services provided to the patient herein.

HIPAA Acknowledgement of Privacy Practices

Initials

I have received a copy of SCHC "Notice of Privacy Practices". This Notice details the various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act.

Patient Rights & Responsibilities

Initials

I have received a copy of SCHC's "Patient Rights and Responsibilities". This Notice details my rights as a patient and expectations of me throughout the course of my care at SCHC.

Patient/Guardian signature:_____ Date:_____