**Community Health of East Tennessee - GENERAL CONSENT FORM**

*The following will be in effect unless specifically revoked in writing, updated, or a change in policy.*

*Our Staff may go over this form in the office with patient.*

Patient's Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Initial*

CONSENT FOR TREATMENT: I do hereby voluntarily request care at Community Health of East Tennessee, Inc (CHET) for myself and or the members of my household that I designate. Care can be (but not limited to): in person, telephonic, telemedicine or via portal. I hereby authorize and grant my permission and consent for all physicians, physician assistants, nurse practitioners and clinical staff employed by CHET to use such diagnostic and treatment procedures they deem necessary for proper medical management of myself and to said members of my household. The clinic, its medical staff and employees are hereby released from any liability for the results of such procedures.

PRESCRIPTION ACCESS: I Consent to give CHET Practice access to my Medication/Prescription History to assist in proper medical management- **Circle one: YES / NO**. If your answer is No, our practice will not see you as a patient.

LIVING WILL & DURABLE POWER OF ATTORNEY FOR HEALTH CARE: (For Patients 18 years old and older) I have been notified that written materials explaining my right to execute a Living Will and/or Durable Power of Attorney for Healthcare to assist in healthcare decisions are available to me. Please notify a nurse if you have any questions about a LIVING WILL.

Do you have a Living Will? Yes No Unable to answer

Do you have a Durable Power of Attorney for Healthcare? Yes No Unable to answer

Has a Copy been given to our office for your chart? Yes No

FINANCIAL AGREEMENT: I understand that my insurance is a contract between myself and the insurance company, not between the insurance company and the doctor. I understand that any balance remaining after insurance pays or denies payment, is my responsibility to pay.

 I hereby authorize and request my insurance company to pay directly to CHET the amount due in my pending claim. I understand that when lab work is done at CHET, I will be billed from the Health Center. Outside lab work will be billed to me from LabCorp, Quest or Dermatopathology ., Inc. X-rays taken at CHET will be sent to Abercrombie Radiology for Interpretation and billed to me by the Radiologist. Pathology reports will be billed by University Pathology or Dermatolopathology.

NON-COVERED SERVICES: I agree to be financially responsible for any charges associated with services which are not reasonably necessary for the diagnosis or treatment of myself or said members of my household, but are provided for the convenience of the patient, his/her family, or physician regardless of payor source.

INFECTION CONTROL: if any employee of CHET is exposed to my (or person I am responsible for) blood or other body fluids, I hereby authorize CHET to test my blood for Hepatitis B, Hepatitis C, and HIV (the virus that causes AIDS). I understand the tests will be done at the expense of CHET.

SMOKE FREE POLICY: I have been informed of CHET's smoke free policy and understand smoking and the use of tobacco products is not allowed on CHET property, including outside. Vapor type e-cigs are also prohibited.

TREATMENT OF A MINOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has permission to bring my child (who is under the age of 18) to Community Health of East Tennessee, Inc Clinic for treatment and make necessary decisions.

TITLE VI: I have been offered a copy of CHET Title VI Information Form, informing me of my right to file a complaint. Instructions and addresses for filing a complaint was included on this form.

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*Initial*

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FAILURE TO KEEP APPOINTMENTS: CHET maintains a policy that the practice can discharge a patient who routinely fails to keep appointments without cancelling. If you cannot keep your appointment for any reason, please call our office ahead of the appointment day; so that the appointment can be made available to someone else who needs our services.

PRESCRIPTION REFILLS: CHET providers do not refill pain medications over the phone. CHET providers do not replace lost or stolen prescriptions. For refills of other types of medications, call your pharmacy first and they will send a request to our provider to refill your medications. Please allow your pharmacy at least 1 business day to receive the request back before checking with your pharmacy to see if it was filled.

NOTICE OF PRIVACY PRACTICES: CHET Notice of Privacy Policies has been provided to me and a copy is available in the lobby. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment. It also describes my rights and the duties of CHET with respect to my protected health information.

THIRD PARTY CONTACT: I authorize I may be contacted via Phone/Mail by a Third Party regarding by financial obligation for services rendered.

Name of Patient’s Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Patient’s Visit today work-related, automobile or other accident related? □ No / □ Yes, Date of Injury \_\_\_\_\_\_\_\_\_\_\_\_

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I consent to the use or disclosure of my protected health information by CHET for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of CHET. I understand that I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. CHET is not required to agree with the restrictions that I may request. However, if CHET agrees to a restriction that I request, the restriction is binding on CHET. My protected health information means health information, including my demographic information, collected from me and created or received by my physicians, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. I have the right to revoke consent in writing at any time except to the extent that CHET has taken action in reliance on the consent. CHET reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Practices policies by calling the office and requesting a copy to be sent in the mail or asking for one at the time of my next appointment.

Please list the persons, if any that CHET may release information to on your general medical condition treatment and diagnosis.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the persons, if any who we may inform about your medical condition ONLY IN AN EMERGENCY.

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Telephone number where you wish to receive calls about your appointment, lab, and x-ray results, or other healthcare information, if other than your home number ( ) \_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_

This office may use a PIN number as a way to confirm consent to speak on phone, what would you like your PIN number to be:

By affixing signature below, I agree to the above, including Notice of Privacy Practices & Consent for Treatment

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian's Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(For Office Use Only)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained: Rev 10/2020

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| --- | --- | --- |
| Individual refused to sign | Communication barriers prohibited obtaining the acknowledgement |  |
| An emergency situation prevented us from obtaining acknowledgement  | Other (please specify) |