

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_**

**CONSENT TO TREATMENT**   
  
I consent to the treatment of myself or my minor child by Community Health Center, Inc. (“CHC”). I understand that if I am completing this consent on behalf of my child that “I”, “me” or “my” refers to my child. I understand that I am giving consent for routine treatment or services that are considered necessary or advisable for me. I understand that I have the right to refuse interventions, treatment, care, services, tests, or medications to the extent that the law allows. I understand that the care I will receive may include voluntary tests (including an HIV test), medications, injections, etc., that are based on established medical criteria, but not free of risk and that I will be advised of any such risks prior to agreeing to any test, medication, injection, etc. I understand that health professions trainees and students may participate in my care under the supervision of CHC staff.

**USE AND DISCLOSURE OF INFORMATION**  
  
I authorize CHC to use and disclose my health information for the following purposes: (1) to provide for, arrange or coordinate my health care treatment; (2) to maintain my health information in an electronic health record system and to use secure technology to improve healthcare delivery; (3) to enable CHC to obtain payment for the services it provides to me; and (4) to permit CHC to carry out ordinary health care and business operations such as quality assurance, service planning and general administration.  
  
I am aware that this authorization to use and disclose information may include information regarding: (1) HIV or AIDS; (2) alcohol or drug treatment; (3) psychiatric or behavioral health; (4) sexually transmitted diseases; (5) family planning, pregnancy and abortion. I am aware and agree that CHC may share information with my other medical providers for medical treatment or with a third party for financial payment through electronic means.  
  
I authorize CHC to request and use my prescription medication history from other health care providers and/or third-party pharmacy benefit payers for treatment purposes. This consent form will remain in effect until the day I revoke consent. To revoke consent at any time, I will speak to a CHC Patient Services Associate.

**ASSIGNMENT OF BENEFITS**  
  
I assign to CHC all benefits to which I may be entitled from Medicare, Medicaid, other government agencies, insurance carriers or other third parties who may be financially liable for the medical care and treatment provided by CHC. I authorize the release of information required by the insurance company for billing purposes and realize that proof of insurance coverage needs to be provided for CHC to file an insurance claim on my behalf. I agree that any benefits paid by my insurance carrier will be paid to CHC. I agree to notify CHC immediately of any changes in my insurance.

**FINANCIAL OBLIGATIONS**  
  
I agree that, except as may be limited by law or CHC’s agreements with third party payers, in the event of non-payment by my insurance for which I have provided an assignment of benefits, I am obligated to pay all amounts due for services provided at CHC locations in accordance with the rates and terms of CHC in effect on the date of service. I also agree that I am responsible for any applicable copayments, coinsurance or deductibles. I understand should I fail to provide any requested information to my insurance company or CHC, CHC reserves the right to bill me for services at the full fee. I understand that failure to pay will result in a full review, including a review of all options available to me such as a payment plan or fee reduction, and, in some instances, may result in termination from the practice.

I understand that I have access to CHC’s payment plan, fee reduction and sliding fee scale discount program for charges based on my income, and I agree to notify CHC immediately of any changes in my income. I understand that I should speak to a CHC Patient Services Associate if I have questions about the sliding fee scale discount program.

**CONTACT RELEASE**  
  
CHC routinely contacts patients by phone, email, text message and/or mail to remind them about appointments; notify them of available test results and recommended routine exams, tests and vaccinations; inquire about bills and insurance; and notify them of other CHC programs and services.

By providing CHC with a cell phone number, I acknowledge that I consent to receiving the above types of text messages. I understand that I can change my communication preferences at any time by speaking with a CHC Patient Services Associate.

**ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**

My electronic signature below acknowledges that I have been offered or received a copy of CHC’s Notice of Privacy Practices (NPP) and that I can access a copy any time at <https://www.chc1.com/privacy-statement/>. The NPP describes how CHC may use or disclose health information about me, my rights related to my health information and how to file a complaint if I feel that my rights have been violated. I have had the chance to review and ask questions about CHC’s Notice of Privacy Practices.

**HEALTH INFORMATION EXCHANGE**  
  
A health information exchange (HIE) allows CHC to share clinical information through an electronic platform with other doctors, nurses, hospitals, healthcare facilities, insurers and government entities when allowed by law. HIEs provide real-time access to health information, which could prove useful in an emergency and generally improves coordination and quality of care. CHC participates in the state mandated HIE, known as CONNIE, and with the national HIEs associated with its electronic health record system.

*State Mandated HIE*

Connecticut requires all healthcare providers to participate in the state’s health information exchange (CONNIE). By state law, all patients are automatically included in CONNIE. This means that unless a patient opts-out of having that patient’s information shared through the CONNIE, patient information will be shared through CONNIE with other treating providers, state agencies and insurers as permitted by law. The only way to opt-out of this HIE is through CONNIE directly. I understand that I can opt-out of CONNIE by visiting <https://connect.conniect.org/OptoutForm> or by calling 866-987-5514.

Sensitive information including HIV/AIDS, behavioral health and substance use disorder information (Sensitive Information) will not be shared with CONNIE without my consent. I understand that I can consent to sharing my Sensitive Information by checking the box below. I will leave the box empty if I do not wish to participate.

*HIEs Associated with the Electronic Health Record System*

CHC’s electronic health record system (EHR) participates in national HIEs (EHR HIEs). These EHR HIEs assist in providing the best possible care by allowing providers outside of CHC who also use the same EHR to see patients’ clinical information when relevant.

By checking the box below and agreeing to participate in the EHR HIEs, I understand that healthcare providers and authorized personnel that participate in the EHR HIEs will be able to access my health information more effectively and accurately. I understand that shared information may include sensitive information such as HIV/AIDS, behavioral health and substance use disorder information (Sensitive Information).

I understand that if I want to participate in the EHR HIEs and to have CHC share my information, including Sensitive Information, I will check the box provided below. I will leave the box empty if I do not wish to participate.

*Consent to Share with HIEs*

***If you wish for CHC to share your Sensitive Information with CONNIE and if you wish for CHC to share your information including Sensitive Information with the EHR HIEs, please indicate your consent by checking the box below. If you leave the box blank or unchecked, CHC will not share Sensitive Information with CONNIE or any information with the EHR HIEs.***

□ I agree to allow CHC to share my Sensitive Information with CONNIE and my information, including Sensitive Information, with the EHR HIEs.

**PATIENT RIGHTS & RESPONSIBILITIES**

I understand that CHC prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression. As a patient, I have the right to:

* Be treated with dignity and respect by all staff and providers;
* Have my treatment and other health information kept private except in an emergency or as otherwise provided for by law;
* Be free from unlawful discrimination;
* Receive services from a provider who has met the qualifications of training and experience required by state law;
* Be informed of the cost of healthcare services before receiving the services;
* Access my records in accordance with the law;
* Take part in treatment planning;
* Refuse any service or treatment unless mandated by a court;
* Report complaints to CHC, my provider, and/or to the Department of Public Health;
* Terminate the provider-patient relationship at any time; and
* Receive appropriate referrals to other providers whenever requested, as well as in the case of a patient termination.

The following are my responsibilities as a patient:

* Treat CHC’s diverse staff and providers as well as other patients and visitors with dignity and respect;
* Do not engage in inappropriate, aggressive, harassing, violent, abusive or threatening behavior (e.g., swearing, yelling, name-calling, physical violence, damage to property, threats of violence, etc.);
* Follow CHC policies and procedures and staff instructions while at CHC;
* Raise any concerns/questions with the provider regarding my treatment or the services I receive;
* Follow the treatment plan on which my provider and I agreed and let my provider know if the treatment plan no longer works for me;
* Keep my appointments and arrive on time;
* Contact CHC as soon as possible if I need to cancel a visit;
* Ensure that minors are accompanied to visits; and
* Pay my co-pay, co-insurance or any amount due at the time of the visit.
* Notify CHC of any change in income if I participate in the sliding fee scale discount program.

**By signing my name below I am acknowledging that I have read and understand the above information.**

**Signature of Patient or Legal Guardian Date**

**Print Name of Patient or Legal Guardian \*\*If not patient or parent, proof of legal authority must be provided\*\***