Blessing Community Health Center

Consent for Services

Patient Name: _____
Date of Birth: _____

The mission of Blessing Community Health Center (BCHC) is to provide quality healthcare and case management services. Our goal is to ensure that all members of our community receive care in a manner that best meets your needs, regardless of race, gender, ethnicity, or religion. To best serve you, we require you to **initial each section and sign below** to provide consent for the following:

_____**Initiation of Services-** I agree to provide the requested information to the BCHC staff to help them better understand my needs and to cooperate to the best of my ability with care recommendations.

_____**Confidentiality-** I understand that all of my information, including health care information, will be kept private and confidential, unless I provide written authorization for it to be shared with someone else, except when my information must be released for legal reasons. These reasons include:

- A court order requires BCHC to release information.
- I am in danger of self-harm or harming others.
- I am a possible victim of abuse or neglect.

_____**Confidentiality: Substance Abuse and/or Behavioral Health Records-** I understand that this clinic offers a variety of services and because of this, staff is allowed to view all of my records as part of providing full scope of care.

_____**Notice of Privacy Practices-** I have been provided a notice of Privacy Practices which explains in greater detail my rights to privacy and how I can access my records. The BCHC staff has answered my questions regarding the Privacy Notice and I consent to release my information to my health plan for the purpose of billing claims, certification, case management, quality improvement, benefit administration and other related purposes.

_____**Hospital Admissions/ER Visits-** I agree to notify BCHC every time I seek care at a hospital and will provide my BCHC provider with copies of my hospital records if I have them.

_____**Emergency Access-** I understand that BCHC does not have after-hours clinicians to handle emergencies and I will call 911 or go to the nearest emergency room in case of emergency.

_____**Advance Directive and/or POLST-** I understand that it is important to have my health care wishes in writing should I become too ill to verbally communicate them. I have provided this documentation to the BCHC staff for my records. If I do not have an Advance Directive or POLST, I will be provided additional education regarding this unless I specifically decline further education.

_____**Medication Management-** I have provided BCHC the name of a preferred pharmacy for my prescriptions and agree to only take medications (prescribed or over-the-counter and/or controlled substances) as recommended. I acknowledge that, if I need a refill, I will request this at least 5 days in advance, and this may only be provided with physician authorization and if I have a nearing, upcoming appointment. Further, some prescriptions cannot be called in and can only be provided at my office visit. I understand that, if I am seeking treatment to assist with substance use or medication management, these require regular scheduled appointments to be successful with my treatment plan and I will keep these appointments to the best of my ability. (For patients seeking treatment for controlled substances, please see "Controlled Substance Agreement" Form).

_____ **Medication History-** It is very important that your provider know all medications you are taking. By initialing this consent form, you are giving your healthcare provider permission to obtain your medication history from your pharmacy, health plans, or other healthcare providers.

_____**Referrals Requiring Authorization-** BCHC recognizes how important timely care is, which may include tests and treatment that need approval by my insurance. I understand that this process may take several days in order for my insurance to review my medical needs. I further understand that BCHC will keep me updated regarding this process and answer any questions I may have.

_____**Appeals and Grievances-** I have the right to appeal through my insurance when my care is not certified for coverage and that there is no penalty to me in exercising this right. I also understand that I may submit a grievance to BCHC or my insurance at any time that I want to file a complaint regarding my care. I further understand that I can contact the California Department of Managed Health Care at 800-400-0815 for complaints regarding my managed insurance or grievances regarding an appeal. If I do not have a managed insurance plan, I can also call the local Department of Public Health regarding my complaints or concerns regarding my care at 909-383-4777.

_____**Consent for Coordination with Insurance Company-** I authorize the release of information to my insurance company as necessary for coverage of my services at BCHC. I further authorize use of my signature to file insurance claims and authorize my insurance to issue payment to BCHC and its providers for services rendered.

_____**Consent for Assessment/Diagnostic Work-up and Treatment-** I authorize and request for my health care and behavioral health care provider to provide all needed diagnostic treatment services that best meet my needs. I understand that, through the course of my treatment, my provider will explain all procedures to me and that they are subject to my agreement. I further understand that while my treatment is intended to be helpful, each patient's response to treatment may be different and outcomes may vary.

_____**Chronic Care Management-** I agree to allow Blessing Community Health Center (BCHC) to provide me with chronic care management (CCM) services and to be designated as my CCM provider. I also understand that other physicians, from time to time, may provide CCM services to me under this consent and will receive my medical information electronically from my CCM Provider electronically or via fax.

☐ I choose not to use BCHC for my CCM Services.

_____**HIPAA Privacy Authorization to Individuals:** As required by the Health Insurance Portability and Accountability Act of 1996, BCHC may not use or disclose your health information to anyone without your authorization, except as provided in our Notice of Privacy Practice. Your signature on the following section indicates that you are giving permission for the uses and disclosures described herein.

I, _____ (printed name of patient or minor child), hereby authorize BCHC to use and/or disclose my complete protected health information, including billing matters, conditions, treatments, prognosis, as well as mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse to the following individual:

1._____Relationship:_____Phone#:_____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties by the authorized individuals above and is therefore no longer protected. I understand that I may revoke this authorization at any time by completing an Update Authorizations & Disclosures form and returning it to BCHC. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to initial this authorization, and that my ability to obtain treatment will not depend on whether or not I initial this authorization.

Signature: _____

Date: _____

Witness: _____