East Liberty Family Health Care Center

A CHRISTIAN MINISTRY OF WHOLE PERSON HEALTH CARE

Consent to Treatment, Record Release, Payment, and Health Care Operations

Consent to Treatment

By my signature below, I acknowledge that I have requested health care services from the East Liberty Family Health Care Center (ELFHCC). I freely and voluntarily authorize and give my consent to the medical, dental, nursing and other staff ELFHCC to provide to me health care services, administer medication and perform diagnostic and therapeutic tests, procedures and treatments as are indicated for my care.

Records

I give my permission for East Liberty Family Health Care Center (ELFHCC) to release my medical information, including electronic medical records, to my insurance carrier, physicians and other healthcare providers involved in my care and to the organizations in which they practice.

Appointments

I agree to keep scheduled appointments and to follow through on the care plan(s) or agreement(s) I make with the health care provider. Should I be unable to keep an appointment, I agree to notify the Health Center 24 hours in advance to cancel and/or reschedule. I agree to be courteous and respectful to all the staff and providers at East Liberty Family Health Care Center.

Billing

I authorize East Liberty Family Health Care Center (ELFHCC) to bill my insurance carrier and request such payments to be made directly to East Liberty Family Health Care Center. I certify that the information I have given about my insurance coverage or other payment sources is correct. I authorize East Liberty Family Health Care Center to act on my behalf and as my representative to request reconsideration by my managed care plan or utilization review entity for coverage.

Financial Responsibility

In order to provide health care services consistent with the East Liberty Family Health Care Center's mission statement, I understand that the East Liberty Family Health Care Center requires that their patients contribute toward the cost of the health care received, as they are able. In order to fulfill this mission, I understand that East Liberty Family Health Care Center is committed to providing health care services with consideration to their patient's ability to pay and to respect the financial responsibility of all their patients.

I understand that East Liberty Family Health Care Center offers financial counseling services, which includes the sliding fee discount schedule. The sliding discount takes into account family size and income.

Consent to Obtain External Prescription History

I authorize the East Liberty Family Health Care Center and its affiliate provider to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers maybe be viewable by my providers and staff at the East Liberty Family Health Care Center, and it may include prescriptions for several prior years.

MY SIGNATURE BELOW CERTIFIES THAT I
READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS

Privacy Practices

I acknowledge that I have received a copy of the East Liberty Family Health Care Center's Notice of Privacy Practices, which describes how my private health information may be used and disclosed by East Liberty Family Health Care Center, and how I may obtain access to and control the use and disclosure of this information.

I have read this Consent to Treatment, Record Release, Payment, and Health Care Operations and have had any questions answered to my satisfaction.

Signature____Date ________________

If the patient is a minor or has a legal representative, please have parent or representative sign here:

Signature____Date _________________

(Relationship to the patient) ____