Bluegrass Community Health Center

CONSENT TO TREAT AND HIPAA

Patient First Name	Last Name	Middle	Patient Date of Birth:

My signature below attests that I am the ☐ **Patient** or I am the ☐ **Biological/Adoptive Parent** ☐ **Legal Guardian; or**
☐ **Foster Parent** for the patient named above and my agreement of the below terms.

AGREEMENT OF CHARGES
I acknowledge responsibility for all charges incurred by me (or any person for whom I am responsible) for services rendered. I agree to pay you regular charges for clinical services rendered.

If I am covered by an insurance plan that is accepted at Bluegrass Community Health Center, my insurance company will be billed. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of benefits directly to BCHC. My health insurance may pay all or part of BCHC's fees. I agree to pay the balance of those charges which are not paid by my health insurance.

If I am uninsured, I will be provided a complete accounting of all charges and I am responsible for such charges at the time of service. I understand that I must pay for contraception, 3rd party labs, optional procedures and immunizations before those orders are performed.

I will submit a verification of household income at or before my initial visit and each year thereafter if I wish to apply for discounts. I will inform BCHC of any changes in my household income and/or household members as this information will be used to determine the amount I pay.

CONSENT TO TREAT
I hereby voluntarily consent to outpatient care including routine and diagnostic procedures. As part of the medical procedures or tests, I may be tested for human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease when such test is ordered by my provider for diagnostic purposes and vaccines. Additionally adults and adolescents are routinely screened for psychiatric needs, reproductive health, and substance use as part of holistic patient care. Screening results and treatment options for psychiatric symptoms and substance use will be shared with parent(s)/guardian(s) of adolescent patients at the provider's discretion.

I hereby authorize the release of information acquired in the course of my registration, examination, or treatment to the Bluegrass Community Health Center staff, as well as to other health care providers, for the purpose of continuing care. For example, because medical and behavioral health services are integrated at BCHC, I understand that my medical provider may share information with my behavioral health provider and vice versa in order to maximize my treatment. Furthermore, if I am referred to an outside provider for specialty care or other service, I understand that the relevant portion of my medical record will be sent to the referral provider in order to coordinate care.

NOTICE OF PRIVACY PRACTICES
I have received a Notice of Privacy Practices from Bluegrass Community Health Center that informed me of my rights regarding how my health care provider may use and disclose my protected health information and Bluegrass Community Health Center's legal duties and privacy practices with respect to protected health information.

By signing this form, I acknowledge receipt of this information and agree to the terms.

_____ _____
Patient or Parent/Legal Guardian Signature **Date**

please continue on back

Bluegrass Community Health Center

PROXY FORM FOR MINOR PATIENTS

Patient First Name	Last Name	Middle	Patient Date of Birth:

For Biological/Adoptive Parents and Legal Guardians Only

Below you may list individuals who can consent to treatment (vaccines, medications, procedures, visits, etc.) for the patient listed above. Individuals will be asked to a present government issued photo ID. I understand that this form will remain in effect for 1 year and to make a change I must come in person to update this authorization.

Authorized Individuals:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

For Minor Patient 16 Years of Age or Older

☐ I authorize the minor patient referenced above to seek care and treatment without a parent/guardian present (except for sports or school physicals).

By signing this form, I acknowledge receipt of this information and agree to the terms.

_____ _____

Patient or Parent/Legal Guardian Signature **Date**