Consent for Treatment

Patient Name: _____ **DOB**: _____ **Date**: _____

I hereby give my consent and authorize Community Health Programs (CHP) to treat any medical, dental, or behavioral health condition providing that the provider has explained the condition to me, the treatment procedures and alternative methods of treating my condition. The provider will/has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.

I authorize the provider to perform any additional or different treatment, which is thought necessary should, during treatment, a condition be discovered which is not known previously.

I understand that CHP integrates medical, dental, nutrition, physical therapy, obstetrics/gynecology, behavioral health, and family services. As a result these additional professionals may be part of my treatment team and experience which may result in my being seen by these providers and may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. I acknowledge that in cases of insufficient insurance coverage, I will be held responsible for the remaining balance.

I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.

Treatment, Payment and Data Agreement

- I authorize examination and treatment for this and all associated CHP visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify for CHP's Sliding Fee Scale via the Sliding Fee Application process administered by CHP's patient assistance enrollment specialist.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize the release of all information necessary to secure payments of benefits.
- I understand that CHP may use data developed for and/or provided by patients to determine general characteristics of the communities it serves; that none of this information will in any way identify individual clients.

I certify that the above information is true and correct. I have been notified of CHP's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature: _____ Date: _____

Guardian/Legal Signature: _____ Date: _____

General Information: Informed consent will be obtained from all patients accessing CHP services. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education. Signature will stay valid unless otherwise revoked in writing.

The patient and/or family, as appropriate, is given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The provider primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.