Community Health Center of the North Country

Consent for Treatment

Patient Name: _____ **Date of Birth:** _____

I hereby give my consent and authorize Community Health Center of the North Country (CHCNC) to treat any medical, dental, eye care, or mental health condition providing that the care provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. The care provider has discussed with me foreseeable risks of the treatment and that there may be undesirable results.

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

I understand to better serve the needs of CHCNC patients, some services are available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of a number of healthcare diagnoses. This process is referred to as “teledental”, “telemedicine” or “telehealth”. This means that you may be evaluated and/or treated by a healthcare provider or specialist from a distant location. I understand services provided are a billable service, which may result in co-payment or co-insurance. I acknowledge that in case of insufficient coverage, I will be held responsible for the remaining balance.

I understand that CHCNC operates a primary care practice that integrates behavioral health services, which means behavioral health staff are part of my medical team and experience, and that being seen by a behavioral health provider through primary care may result in additional charges to my insurance. This may also result in an additional co-payment or co-insurance. I acknowledge that in case of insufficient 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 following medical, dental, eye care, or mental health visits.
- I understand that I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- 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 release of all information necessary to secure payments of benefits.
- I understand that Community Health Center of the North Country may use data developed for and/or provided by patients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual patients.
- I authorize release of immunization(s) information to the New York State Immunization System (NYSIIS).

I certify that the above information is true and correct. A copy of Community Health Center of the North Country’s Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities has been made available to me.

Patient/Legal Guardian Signature: _____ **Date:** _____