

GENERAL CONSENT FOR TREATMENT AND BILLING

I, the undersigned, give permission for myself or minor child, as indicated above, to undergo all necessary tests, examinations, treatments, or other procedures required by the medical, mental, behavioral health staff for Community. I Realize that the practice of medicine, surgery, and dentistry is not an exact science, and acknowledge that no guarantees have been made to me as a result of treatments or examinations by CHI.

I consent to the release of medical information to other institutions or agencies accepting me for medical or institutional care, and consent to release my medical information and data (both medical and personal) to my health insurance payer and government agencies as required of CHI by law, rules, regulations, or by consent.

I consent to the release of medical and financial information for auditing purposes.

I hereby authorize payment to CHI of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS, otherwise payable to me, but not to exceed the health center and/or physician regular charges for this period of treatment.

I agree that a copy of this authorization is valid as the original.

I understand that if my insurance does not approve the charges for this visit, I am fully responsible to CHI for payment.

I understand and acknowledge that CHI is a teaching facility and therefore, may have medical, dental, and psychiatric residents as well as medical, dental, pharmacy, nurse practitioner, and nursing students participate in my care under the supervision of my physician, dentist, psychiatrist, or nurse practitioner.

I have the right to know their names and professional relationships to CHI, as well as the name of their attending physicians so that I know who I can bring any concerns that I may have.

I understand that all oral procedures, equipment, and supplies may not be covered by the sliding fee discount and out of pocket.

I understand that Telemedicine/Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time

I give my consent for the sharing of my personal health information with CHI and its physicians/providers.

I understand that I have the right to withhold or withdraw my consent to the use of Telemedicine/Telehealth during the course of my care, at any time, without affecting my right to future care or treatment.

I consent to receive text messages regarding my appointment(s) that do not include any Protected Health Information.

I consent to receive Emails to my personal email address regarding any Medical Information which may include: Referrals, Immunization records, School related forms, Medical Forms that you have requested your provider to complete.

MEDICARE PATIENTS ONLY:

I authorize any holder of medical or other information about me to release to **Center for Medicare and Medicaid (CMS)** or its intermediaries or carriers or its intermediaries or carriers, any information needed for this or any subsequent Medicare Claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party that accepts assignment for such claim.