UNION COUNTY HEALTH DEPARTMENT

NURSING CLINIC SERVICES

GENERAL CONSENT FOR MEDICAL SERVICES

Thank you for choosing Union County Health Department (UCHD) to serve your healthcare needs. We want you to be healthy! The more you know about your health, the better. I give my consent to the staff of the above-named clinic to examine, treat and counsel me. I understand and agree with:

Clinic Services

It is my choice to receive services at this clinic and I can change my mind about receiving services at this clinic at any time.

UCHD is committed to provide services in such a way as to protect each person's dignity, without regard to religion, race, color, national origin, language ability, handicapping conditions, age, sex, gender, sexual orientation, number of pregnancies, or marital status. For those receiving family planning services, you do not have to accept any other services, assistance from, or participation in, any other program offered at the Union County Health Department (UCHD). Services are provided without requirement to employ or not employ any particular method of family planning.

I may be given referrals for further diagnosis or treatment when necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care.

I understand that a clinical staff member is available to answer questions I may have today or during normal business hours. For questions or concerns related to the care received through UCHD clinic services, I will call the Union County Health Department at 937-642-2053, or toll-free for long distance at 888-333-9461.

In an emergency, I have been advised to call 911 or go to the nearest emergency department.

For urgent needs beyond clinic hours, I may consult a medical provider, go to an urgent care, or go to an emergency department. There are certain hazards and risks connected with all forms of medical care and treatment that may result in additional costs to me (the patient).

Privacy

All information about me is kept in strictest confidence and will not be released to anyone without my permission, except as required by law. We will share your health information when required to do so by international, federal, state or local law; statutes; regulations; or court orders. Your health information may be shared to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Your health information may also be shared:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report adverse reactions to medications or problems with products, or to notify of recalls of products
- To provide proof of immunization where proof is required for student admission to school
    - I understand that this health care clinic uses a statewide database (IMPACT SIIS) that makes my health information available to the Ohio Department of Health for immunization program reporting purposes.
- To report child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, domestic violence and/or human trafficking
- To carry out treatment, payment, care coordination, and healthcare operations such as appointment reminders, insurance claims, laboratory results, and other healthcare information.

Minor-Aged Patients

Minors not seeking reproductive health services, must come with an adult or parent/guardian. The parent/guardian is responsible for payment of any fees not covered by the insurance plan. If the adult accompanying the minor is not the parent or guardian, he or she will need to provide appropriate written documentation from the parent/guardian. We may not treat minors unless we have received this written permission.

By law, minors (ages 13+) seeking reproductive health services may attend appointments with **or without a parent/guardian present. Confidential services are always provided, although family participation is strongly recommended.

Receipt of Notice of Privacy Practices

_____ (initial) I have been offered the UCHD Notice of Privacy Practices which outlines how my Protected Health Information may be used and disclosed, and how I can get access to the information.

Photograph for Patient Identification

_____ (initial) I give my consent to using my photograph for identification on my electronic health record.

Telephone Contacts, Monitoring and Recording

_____ (initial) I have established a relationship with UCHD and agree that UCHD (or anyone working on behalf of UCHD) may text, e-mail or use an automated dialing device to: (1) contact me regarding my most recent visit with my provider; and (2) inform me about new services or suggested health screenings.

Health Information Exchange (HIE) and Patient Information Access

UCHD offers access to a secure patient portal through an electronic medical record which allows for protected access to laboratory results, patient education materials, and communication with your healthcare provider. By providing your email address, you give permission to activate this feature.

Consent

All patients must complete our Consent form before seeing a member of our medical care team.

I have read the above information. It has been explained to me and I understand it. My questions have been answered by a person from the clinic. I have selected UCHD as my medical provider. I am presenting to UCHD and I consent to the services, treatments, and procedures performed and ordered by my physician(s) and other healthcare providers, which may be performed during an episode of care, including, but not limited to, those rendered in person and via electronic means such as telemedicine. I understand that medicine is not an exact science, my diagnosis and treatment may involve risk of injury or even death, and no guarantees can be made to me as to the results of examinations or treatments during any episode of care, and I elect to receive services with full understanding of this information and these potential risks. By signing below, I am acknowledging that I have read and understand the above statements.

_____ (print first and last name) _____ (date)

_____ (signature)

Patient Financial Policy

Insurance

Payment of your bill is considered part of your treatment. Fees are due and payable when services are provided. UCHD accepts cash, check, credit or debit cards, and pre-approved insurance for which UCHD is a contracted provider.

It is your responsibility to know your own insurance benefits, including:

- Whether UCHD is a contracted provider with your insurance company;
- Your covered benefits and any exclusions in your insurance policy; and
- Any pre-authorization requirements of your insurance company.

UCHD will attempt to confirm your insurance coverage before your treatment. It is your responsibility to provide current and accurate insurance information to UCHD, including any updates or changes in your insurance coverage. Should you fail to provide this information, you will be financially responsible for the costs of the services rendered by UCHD. If UCHD has a contract with your insurance company, UCHD will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company. If UCHD does not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. UCHD will provide you with a statement you can submit to your insurance company for reimbursement. Proof of insurance and photo ID are requested of all patients. UCHD will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company. Some insurance coverage has Out-of-Network benefits with co-insurance charges, higher copayments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policy stated above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided, I will be financially responsible and will pay all such charges due and owing in full to UCHD. I also understand that prior authorization or pre-approval by my insurance company is NOT a guarantee of payment. If you have questions regarding your insurance, please ask your human resources representative or ask your insurance company (their phone number is on your insurance card).

Co-pays

Some insurance companies require co-pays. All co-pays should be paid when you check in for your appointment.

Deductible and Coinsurance

If your insurance company applies any charges to your coinsurance or annual deductible, you will be responsible for that amount. It is up to you to check with your insurance plan about deductibles and coinsurance. We can help you to set up a payment plan that fits your financial situation.

High Deductible Health Plans (HSA, HRA, FSA participants)

Let us know before your appointment if you are in a High Deductible Health Plan (HDHP), a Health Savings Account (HSA), a Health Reimbursement Arrangement (HRA) or a Flexible Spending Account (FSA). We will bill your insurance plan first. If there is any remaining amount, we will send you a bill. Let us know if you need to set up a payment plan.

Laboratory Services

Some of your lab tests may be sent out to non-health department laboratories. The lab is an independent provider, not connected with UCHD. The lab will bill your insurance company directly. Any lab costs not paid by your insurance will be invoiced to you by the lab. You will be responsible for any outstanding lab fees. If you have questions regarding lab fees, please contact the lab directly (the phone number will be on your invoice).

Self- Pay Accounts

If you do not have a health insurance plan, ***or*** if you are receiving services not covered by your insurance plan, ***or*** you have an insurance plan that does not have the Union County Health Department in its network, you will be asked to pay for services during your appointment. You can ask our staff if you qualify for a **Sliding Fee Scale** or discounts available for cash payments made at your appointment. We can also help you set up a payment plan if you need one.

Payment Details

UCHD accepts cash, check, credit or debit cards, and pre-approved insurance for which UCHD is a contracted provider. There is a $35 fee for returned checks. The amount of the returned check and the $35.00 fee must be paid before you schedule another appointment.

I have read the Patient Financial Policy. I understand and agree to this Patient Financial Policy.

_____ (print first and last name) _____ (date)

_____ (signature)