GENERAL CONSENT OF SERVICES

Patient Information
First Name: _____
Last Name: _____

Chart No: _____ DOB: _____
Gender/sex: _____

Acknowledgement of Receipt of Notice of Privacy Practices

The Notice of Privacy Practices is a complete description of my rights as a patient of Guilford County Department of Health and Human Services – Public Health Division (Public Health Department). By signing below, I am stating I have received the **GCDHHS- Public Health Department Notice of Privacy Practices**.

Consent for Treatment/Care

I consent to treatment and care by the Guilford County Department of Health and Human Services – Public Health Division (Public Health Department) and by its physicians and health care providers. I also consent to treatment and care by physicians and health care providers who are not employees or agents of the Public Health Department but are authorized by Public Health Department to provide treatment and care to me as a patient of Public Health Department. I understand that my treatment and care may include routine care, such as immunizations, a variety of other medical services depending on my condition, laboratory testing and judgement of the physician or health care provider, and referrals to medical specialties such as mental health and substance abuse professionals. I understand that my care team at Public Health Department may include resident physicians or advance practice providers, students and other trainees. I am aware that the practice of medicine is not an exact science, and no one has made any guarantee about the results of my treatments, examinations, or procedures.

Consent to Telehealth Services

I consent to telehealth services provided by GCDHHS. I understand that services could be provided using apps such as Skype for Business, FaceTime, Zoom, Facebook Messenger, or any other apps available including telehealth services offered via the EMR systems. I understand GCDHHS will take all appropriate measures to keep my information protected and confident.

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Consent for Use and Release of Information

I give permission to Public Health Department– including their treating and referring providers and other staff members – to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); (3) for the health care operations of Public Health Department or another provider that has a relationship with me, such as but not limited to quality assessment, case management and social determinants of health metrics; or (4) as otherwise described in the Notice of Privacy Practices and as permitted by law.

Consent for Use Within Public Health Department

I further give permission to Public Health Department, their affiliates, their treating providers and other staff members to disclose to each other any of my sensitive information necessary for my treatment, including information related to behavioral and/or mental health (including records of my treatment by a facility whose primary purpose is to provide services for the care, treatment, habilitation and rehabilitation of the mentally ill, developmentally disabled, or substance abusers, as defined by NCGS Chapter 122C, Articles 1 and 3), drugs and alcohol (including records of a provider that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

Financial Responsibility

I understand and agree that physician charges for medical and related professional services performed or supervised by a physician will be billed to my insurance policies. I understand that my actual charges may be different from the charges estimates given to me. I understand that I am expected to pay any co-payment, deductible, or non-billable service today. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If insurance is billed, I understand that an Explanation Of Benefits, which lists services provided, may be mailed to the address of the person carrying the insurance. If I do not have health insurance, or have not provided current or accurate information, or I decline to provide income information, I may be responsible for payment of all charges. If verification of eligibility is provided to the eligibility clerk within 30 days, the appropriate refund will be mailed to me. If I have overpaid any of my accounts with the Public

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Health Department, I agree that overpayment may be applied to pay any outstanding charges on any of my previous accounts. If no outstanding balances are found, a refund will be mailed to me. I understand that any fees charged as a result of referral to any other provider/agency are my responsibility. I acknowledge that if I receive STI services today, my insurance policy may be billed for all billable claims.

Medicare/Medicaid/Insurance Certification, Assignment and Payment Request

I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my health care under Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to the Public Health Department on my behalf. I authorize the Public Health Department to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to the Public Health Department.

Social Security Number

I have given my social security number voluntarily, Public Health Department may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Appointment Reminders

By signing below, I authorize the Public Health Department to contact me by automated SMS text messages for appointment reminders. I understand that these are free of charge, however, message/data rates may apply to messages sent by the Public Health Department under my wireless telephone plan. I know that I am under no obligation to authorize the Public Health Department to send me text messages. I may opt-out of this service by calling the main number and that I should allow 2-3 business days for processing.

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Consent for Use and Release of Information to Family Members and Friends

As a courtesy, limited health information may be shared with family, friends and authorized representatives under the following conditions: (1) the information is related to the individual's involvement in the patient's care or payment for care, or (2) the information is needed to notify individuals responsible for the patient's care about the patient's location, general condition and health. Unless I have initialed below, I give permission for limited health information to be shared with my family, friends, and authorized representatives under the conditions mentioned above. Limited health information can be shared with individuals listed in the support section in EMR/EHR.

Decline Release of Information to Family and Friends
Patient Signature: _____

Telephone Number

The Public Health Department or their agents or representatives may contact me by telephone at any number contained in my Electronic Health Record, including wireless telephone numbers, for any purpose related to my treatment and care or for servicing my account and collecting amounts due. The Public Health Department may leave basic information on my answering machine and/or with family members.
Decline Telephone Messages
Patient Signature: _____

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY the Public Health Department, OR IN PROGRESS.

I have read and understand this form, offered a copy, and I am the patient, or I am the authorized representative to act on behalf of the patient to sign this form.

Signature: _____
Relationship, if not patient (Print name): _____

Appointment Date: _____ **Appointment Time:** _____

Interpreter Signature: _____
Interpreter Print Name: _____