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

Consent to Treatment & Acknowledgment of Receipt of Information

Welcome to CrescentCare! We are a Federally Qualified Health Center (FQHC) which provides a variety of services. Services available at CrescentCare facilities include Primary Medical Care, Mental Health Care, Dental Care, Women's Health and Pregnancy Care, Specialty Care for HIV and other Infectious Diseases, Child and Adolescent Care, Behavioral Health Counseling, Case Management, HIV Counseling & Testing, Housing Support, Medication Assistance, Health Education, and various Client Services and Legal Services. These services are available to eligible individuals who participate in CrescentCare's Primary Care Medical Home (PCMH). Some programs have additional eligibility requirements due to funding. We look forward to putting your needs at the center of our planning, and open the doors of our Medical Home to you and your family.

_____ ***Consent to Participate***: I understand that health care delivery is not an exact science, and I acknowledge that no guarantees have been made concerning results of my care at CrescentCare. I authorize my providers to discuss my conditions with other health care practitioners and their agents and employees, in order to provide me quality services.

_____ ***Consent to Release Medical Information***: I hereby authorize, without further consent, CrescentCare and my practitioner to release minimally necessary information requested by my health insurance company, Medicare, Medicaid, and any other third-party payer or its designees for service reimbursement. I also authorize CrescentCare and its employees to act as my *(the patient's)* authorized representatives in assisting me with applying for benefits.

I hereby authorize, without further consent, CrescentCare and my practitioner to release and/or receive minimally necessary information requested by any department or person within the Agency for business reasons or for the purpose of providing services to me. I consent to have my practitioner obtain my medications history electronically.

_____ ***Financial Agreements***: I understand and have received guidance about CrescentCare's policy to provide essential services regardless of my ability to pay. Further, I understand that CrescentCare utilizes fee schedules for services it provides that are consistent with locally prevailing rates or charges and which are designed to cover the reasonable costs of the organization's operation. When I am referred to an outside provider, I know that I must make payment arrangements with them separately. I understand that if I have Medicare coverage, it is likely that Medicare will pay for the services I receive. CrescentCare will provide me with an estimate for any items which Medicare is not expected to pay, as well as the reason for their denial. Any charges not covered by insurance, including Medicare, will be my responsibility.

_____ ***Assignment of Insurance Benefits***: I hereby authorize and instruct my insurance company to pay any and all medical and/or other benefits directly to CrescentCare. I further hereby assign and set over to CrescentCare all my rights, interests, and benefits payable under any plan or policy under which I am entitled coverage concerning services rendered.

_____ ***Communication***: I understand that I will receive communications from CrescentCare from time to time, including mail, e-mail, phone calls or text messages related to billing, care and treatment, appointment reminders and quality of care surveys. I understand that it is my responsibility to tell the Agency about any method that I don't want used for communicating with me.

_____ ***Health Information Exchange (HIE)***: CrescentCare is a participating member of several health information exchanges. A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you.

I hereby authorize without further consent for CrescentCare to share my healthcare information with and to receive my healthcare information from those exchanges. This information may be accessed by another participating provider as part of a normal office visit or in case of an emergency if I were to go to the hospital, emergency room. I understand that I have the right to opt-out of participating in any and all HIEs. This authorization may be revoked in writing at any time except to the extent that actions were taken before the revocation. I understand I may be responsible for charges incurred for services/treatment if I refuse to authorize disclosure of my medical records or if I later revoke this authorization, either of which results in a denial of payment by the insurance or third-party claim payor. Your consent to participate or your refusal to participate in any HIE is not a condition for treatment at CresentCare. Please request an Opt-Out form at any CrescentCare location from the Patient Access front desk. Any questions or concerns can be directed to CrescentCare's Privacy Officer by emailing privacyofficer@crescentcare.org.

Receipt of Documents: By initialing on the lines below, I certify that I have received the following documents along with an explanation of their contents:

_____ CrescentCare Notice of Privacy Practices (HIPAA)

_____ CrescentCare Patient/Client Handbook

Acknowledgment: My signature below constitutes my acknowledgment and agreement that I have read (or had read to me) and I understand the information I was given. I was given the opportunity to discuss this form and ask questions, all questions were answered to my satisfaction, and I am satisfied that I understand the form's contents and significance.

I certify that I have read this form and either am a participant or am duly authorized by the participant's general agent to execute the above and accept these terms.

Printed Patient/Participant Name | Patient/Participant Date of Birth

If not Patient/Participant, Printed Name of Authorized Individual

Signature of Participant or Authorized Individual | DATE

If not Participant, Relationship of Signer to Patient/Participant (mother, father, son, daughter or other: [explain])

For Internal Use Only: Please use this box to detail any information related to the completion of this document.

Patient Access or CrescentCare Staff Name: _____

Patient Access or CrescentCare Staff Signature & Date: _____