neighborcare health

Patient Consent for Care and Treatment

I certify that the registration information that is being reported to Neighborcare Health is currently correct, and I understand that any deliberate misrepresentation of that information may cause me to be responsible for the full charge of services provided to me.

I grant permission for licensed and/or certified medical, mental health and/or dental staff to employ treatment and therapies that are considered professionally and medically necessary. Furthermore, I understand that Neighborcare Health is a teaching facility and teachers, trainees, residents, and students may observe and/or participate in my care.

At times, visits at Neighborcare Health will be performed via Telehealth/Telemedicine. I understand that Telehealth/Telemedicine services allow Neighborcare Health to provide a visit that is not in person and can be performed via a computer, tablet, or a telephone call. I understand that, like in-person visits, Telehealth/Telemedicine visits will be billed to my insurance and/or myself and that I am fully responsible for all services delivered.

I certify that I understand the following regarding Telehealth/Telemedicine:

- I understand that I have the option to refuse Telehealth/Telemedicine services at any time without affecting the right to future care or treatment and without the risk of losing benefits. I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons.
- I understand that if I do not choose to participate in a Telehealth/Telemedicine session, no action will be taken against me that will cause delay in my care and that I may still pursue an in-person visit.
- I understand that like any technology, Telehealth/Telemedicine does have its limitations, including equipment failure and information security risks. There is no guarantee, therefore, that a Telehealth/Telemedicine visit will eliminate the need for me to see a provider in person.

I understand that Neighborcare Health and/or providers who provide professional services to patients are authorized to furnish medical, dental and/or mental health information from my medical records to a referring specialist, if any, and to any insurance company, Medicare (CMS), and/or Medicaid (DSHS) for the purpose of obtaining payment on the account. Neighborcare Health is authorized to release information from my medical record to any other health care facility and/or provider to which my care may be transferred.

This authorization shall remain in effect for a year from the date signed unless the consent is canceled by written notice to the Chief Health Officer at Neighborcare Health. This assignment and release authorize Neighborcare Health to release to my insurance company, Medicare (CMS) and/or Medicaid (DSHS) any information needed to determine the benefits payable for related services. I hereby authorize any insurance company, Medicare (CMS), and/or Medicaid

(DSHS) to pay Neighborcare Health directly for services rendered to me. I agree to pay in full for all charges that are not paid in full by the insurance that is left to my responsibility to pay.

PATIENT CONSENT FOR TREAMENT AND CARE
My signature below indicates that I understand and have been advised of the information provided on the Patient Consent for Treatment and Care form. I understand I can ask for a copy of this form.
Patient and/or Guarantor Signature

HIPAA COMPLIANCE AND NOTICE OF PRIVACY PRACTICES
My signature below indicates that I understand and have been advised of the information provided on the Neighborcare Health Notice of Privacy Practices. I understand I can ask for a copy of this form.
Patient and/or Guarantor Signature

PATIENT RIGHTS AND RESPONSIBILITIES
My signature below indicates that I understand and have been advised of the information provided in Neighborcare Health's Patient Rights and Responsibilities. I understand I can ask for a copy of this form.
Patient and/or Guarantor Signature

RELATIONSHIP TO PATIENT