ERIE COUNTY COMMUNITY HEALTH CENTER
420 Superior Street – Sandusky, Ohio 44870 419-626-5623 / Fax 419-626-4824

INFORMED CONSENT

_____ _____
Client Name Date of Birth

I give my consent for the Erie County Community Health Center (ECCHC) to provide treatment. _____ (initial)

RELEASE/SHARING OF INFORMATION

I authorize the ECCHC to **release** and **obtain** verbal, written and electronic health information about the above-named client to and from health care providers involved in the medical and/or dental treatment and management of the client's medical or dental care and with specialists we may refer to. This release may include all health care including behavioral, mental health and addiction care pertinent to my medical/dental treatment at ECCHC. _____(initial)

I authorize release of all health information except: _____

I understand that these records are protected under federal and state laws and regulations and cannot be disclosed without my written consent unless otherwise provided by law.

I authorize the ECCHC to release any information from the client's medical/dental records to medical assistance, Medicare, other governmental payers, private insurance companies or plans or organizations acting on their behalf, as may be necessary to determine benefits and process claims and others involved in the collection of accounts.

PAYMENT OF SERVICES

I authorize (name of insurance company) _____ to assign the amount payable under the client's contract directly to the ECCHC. I understand that I am financially responsible for all charges that are not covered by private insurance company. I also understand that I am responsible for knowing the benefits covered under the client's private insurance plan.

I understand that I am responsible for notifying the ECCHC if there is a change in the insurance coverage, my address and my telephone number.

I acknowledge that co-payments or nominal fees are due and payable on the date services are received.

I, _____, state that there are _____ people living in my household and household annual income is _____. If declaring no income, I agree to complete and sign the IRS 4506-T form. _____ (initial)

I agree, whether as a patient, agent, guardian, relative, or representative, that in consideration of the services rendered, I hereby individually guarantee and obligate myself to pay the account of the ECCHC in full. I further understand that failure to comply with my responsibilities for payment of services rendered may result in suspension of appointments.

SLIDING FEE SCALE AGREEMENT: I understand and agree that some services rendered are based on my ability to pay. Title X Family Planning clients will not be denied family planning services due to inability to pay. If payment for other services is determined by and based on a sliding fee scale, I understand that I am responsible for my share of the cost of services rendered and that failure to provide "proof of income" will result in being charged 100% of the cost of services received or provided.

RECEIPT OF NOTICES

I have been given a copy of or have read ECCHC's *Notice of Privacy Practices, Patients' Bill of Rights and Patient Responsibilities*. _____(initial)

I have read and understand the ECCHC "No-Show/Cancellation" policy and agree to abide by the guidelines as stated in the policy._____ (initial)

VACCINES

In regards to vaccines, I grant my permission for this record to be released to medical providers, health departments, schools and day care centers. I have received a copy, have read or had read to me the information on the appropriate VIS sheet about the vaccine(s) and my questions were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be administered to me or the person named for who I am authorized to make this request. _____ (initial)

Does the health insurance cover vaccines? YES NO

NOTIFICATION/CONTACT

At times ECCHC will need to notify patients for various reasons. ECCHC will call the patient 2-3 days before an appointment to remind the patient of their upcoming appointment. If ECCHC needs to contact the patient or return a patient's phone call for additional reasons, ECCHC can: (please initial your contact preference)

_____Call my telephone number, but do not leave a message if I do not answer.
_____Call my telephone number and identify ourselves as ECCHC to the person answering or in a voicemail.
_____Call my telephone number and leave a detailed voicemail as to why we are calling.

Please list an emergency contact (if a minor, please provide someone who will not be bringing the minor).

_____ _____
Name/Relationship Telephone Number

If ECCHC is not able to reach you by telephone, would you like us to contact your emergency contact?

_____ NO, Emergency contact will only be used as a contact in an emergency. (Initial)

_____YES: (please initial your contact preferences for emergency contact).

_____ECCHC may call my emergency contact listed and notify them to contact me to call ECCHC and provide no further details.

_____ECCHC may call my emergency contact listed and provide information either over the phone or in voicemail as to why we are calling.

In the event of an abnormal test results and the inability to contact me by all other means, I authorize ECCHC to contact me in writing at the current address provided by me.

Parental Consent of Minor Children: The following individuals are permitted to bring my child for treatment services:

Name	Relationship	Name	Relationship

MINORS MUST BE ACCOMPANIED BY PARENT, LEGAL GUARDIAN OR INDIVIDUAL NAMED IN PARENTAL CONSENT LISTED ABOVE.

I give my consent for ECCHC to provide medical/dental care to the adolescent (age 16 & 17) listed above in the event that I am not present for the appointment _____ (Parent or Guardian Initial)

I am a minor seeking confidential Sexually Transmitted Infection or Family Planning Services □ No □ Yes____ (initial)

This consent is in effect until January 1st following the date of signature.

_____ _____ _____
Signature of Client / Parent or Guardian if a Minor Date Witness