455 Lakeshore Parkway | Rock Hill, SC 29730
T: 803.909.6363 | F: 803.909.6364 | affinityhealthcenter.org

CONSENT FOR TREATMENT

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information and documents. If you have any questions about any of this information or need help completing this form, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information. By signing, you are indicating that you understand the information, have been given a chance to ask questions, and are giving your consent.

GENERAL CONSENT TO TREAT

I voluntarily agree to receive services from Affinity Health Center, and authorize the providers of AHC to provide such care, treatment, or services as are considered necessary and advisable for me. I understand that I should participate in the planning for my care and that I have a right to refuse interventions, treatment, care, services or medications at any time to the extent the law allows. I know that the care I will receive may include tests, injections, and other medications, etc., that are based on established medical criteria, but not free of risk. HIV Testing is included as a routine part of care unless I, the patient, elect to decline testing which should be done by notifying the medical provider. Should it be necessary, I authorize AHC staff to obtain emergency medical assistance for me from the Emergency Medical Service and/or hospital.

INTEGRATED MODEL OF CARE

AHC offers a wide variety of services for its patients. I understand that in order for me to get the best care possible, programs within AHC may share information concerning my health to ensure the quality and continuity of my care across service areas. I also understand that services are delivered by a multi-disciplinary team under the supervision of a physician. I authorize my provider to discuss with parties outside AHC information including diagnosis(es), case history, physical examinations, treatments, and hospitalizations—deemed necessary and appropriate to deliver medical care to me. I request that my protected health information be communicated with others directly involved in my care. The designated care provider listed will keep a copy of this document as a permanent part of my medical record which will be copied as required in order to allow communication of my protected health information, in accordance with HIPAA. I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared to care for me.

SATELLITE SERVICES

I consent to have the Family Resource Center staff at AHC satellite sites assist in the provision of services to me including, but not limited to, interpretation, faxing records, and providing administrative support to AHC staff. All Family Resource Center staff members are business associates of Affinity Health Center and are bound by HIPAA.

PATIENT RIGHTS AND RESPONSIBILITIES

I have been given a copy of the AHC Patient Rights and Responsibilities document and understand that both the Rights and Responsibilities laid out in that document must govern my interactions at AHC. I also understand that AHC and I are responsible for adhering to the Rights and Responsibilities. I understand that I have a right to file a complaint with AHC, as described in the Patient Rights. The Patient Rights contains information about being a patient at AHC and services that AHC offers.

RELEASE OF INFORMATION FOR BILLING

I know that AHC may send parts of my personal health information to organizations that help pay for my care, such as my insurance company or an organization that grants money to AHC. I allow AHC to release the relevant parts of my record so that my care can be paid for. If I do not feel comfortable with this, then I understand that I can request a higher level of privacy protection that is afforded me under the Health Insurance Portability and Accountability Act (HIPAA).

ACKNOWLEDGEMENT OF DUTY TO REIMBURSE AHC FOR HEALTH CARE SERVICES

I understand that AHC offers a Discounted Fee Schedule to individuals who are deemed unable to pay based on their level of income. In order to be eligible for AHC's Discounted Fee Schedule, I will need to provide AHC with documents establishing that I meet income eligibility requirements.

By signing my name below, I am acknowledging that I have read and fully understand each of the separate paragraphs set forth above and consent freely, voluntarily and without coercion. I understand that I may revoke my consent at any time, except to the extent that action has been taken in reliance on this consent.

Patient or Guardian Signature:	**Date:**
Print Name (Print relationship also, if other than patient):	**DOB:**

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PATIENT ACKNOWLEDGEMENT OF FINANCIAL OBLIGATION

Purpose: *Affinity Health Center determines and monitors patients' fees for all medical services provided, utilizing the Community Health Center Discounted Fee Schedule.*

I understand that I am responsible for:

- Contributing to the cost of my care and treatment as my health insurance coverage requires and based on my ability to pay;
- Providing AHC with the information it needs to receive reimbursement for the treatment of services it provides to me;
- Requesting consideration for discounted fees under AHC Discounted Fee Schedule based on my family income, and providing documentation to support eligibility for discounted fees that may be requested by AHC;
- Assisting AHC staff with any application for public benefits that I may be entitled to;
- Paying my co-payment, co-insurance and/or deductible (if applicable) when I check-in for my appointment and/or any other fees that may be owed;
- If my family income is above 200% of the federal poverty level and I am uninsured, I understand that I am responsible for 100% of charges; I will be asked to bring a minimum of $100.00 for each visit and I will receive a bill for the remaining balance;
- Providing proof of income and proof of residence.
- For uninsured patients: I understand that if my family income changes, I will bring documentation of those changes to AHC for assessment on the Discounted Fee Schedule.

Signature: _____

Printed Name: _____

Date: _____

Date of Birth: _____

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PATIENT RIGHTS AND RESPONSIBILITIES

As a patient of Affinity Health Center, I have the following RIGHTS:

1. Considerate and Respectful Care – I have the right to receive considerate, dignified, and respectful care by all employees and volunteers of Affinity Health Center, regardless of my physical or emotional condition.

2. Privacy – I have the right to privacy in matters pertaining to my care; however there may be times when it is necessary to discuss aspects of my care with other Affinity Health Center staff or supervisors involved in my care.

3. Confidentiality – I have the right to expect that Affinity Health Center will maintain complete confidentiality of my records, according to state and federal law. Any information about my specific case that is released to another agency will only be transferred after an *Authorization to Use and/or Disclose Health Information* is signed by myself or my legal guardian. I further understand that my right to confidentiality does not override AHC's "Duty to Warn" responsibility. Duty to warn includes issues such as suicidal/homicidal ideations and /or HIV partner notification.

4. Non-Discrimination - I have the right to quality services without discrimination regarding age, race, ethnicity, color, sex, religion, national origin, economic status, sexual orientation, affectional preference, or disability.

5. Response – I have the right to a response by Affinity Health Center in a timely and reasonable manner when I request services, and the right to be screened as promptly as possible for all services.

6. Access to Relevant Services – I have the right to know what services Affinity Health Center provides, how to obtain these services, and why a service may not be offered to me.

7. Active Involvement in Your Ongoing Care – I have the right to provide AHC staff members with positive or negative feedback about my care or voice my concerns or complaints about the Health Center.

PATIENT RIGHTS AND RESPONSIBILITIES (continued)

As a patient of Affinity Health Center, I have the following RESPONSIBILITIES:

1. Keeping scheduled appointments – I am responsible for keeping appointments with Affinity Health Center staff and for keeping appointments with other agencies that health center staff have scheduled for me. If I cannot keep these appointments, I am responsible for notifying health center staff and/or external service providers prior to the appointment time.

2. Respecting the Agency – I am responsible for treating all employees and volunteers of AHC with considerate care and respect. I am responsible for conducting myself in an appropriate manner while in AHC's office, including but not limited to, respecting personal and professional boundaries, refraining from inappropriate physical contact or speech, and refraining from conduct that threatens, intimidates, or coerces any employee or volunteer. If AHC refers me to an external provider or agency for services, I am also responsible for treating those employees with respect. If I am treated inappropriately by external service providers in which AHC referred me to, I am responsible for notifying AHC staff.

3. Confidentiality - I am responsible for respecting the confidentiality of other persons I may see at AHC. Anything I may hear, see, or read about others will not be repeated, in any form, to any other person.

4. Providing Current Information – I am responsible for making sure AHC knows when my address or telephone number changes, and for informing AHC promptly whenever I have a change in my insurance or financial situation at the time of my appointment.

5. Arriving Sober: – I am responsible for being sober and not under the influence of alcohol or any other mood altering substance not prescribed by a physician when I have a scheduled meeting with any service provider.

By signing my name below, I am verifying that I understand my rights and responsibilities as a patient of Affinity Health Center. I also understand that my services with Affinity Health Center may be terminated if I do not fulfill my responsibilities within this agreement.

Patient/Guardian Signature: _____ Date: _____

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Authorization to Use and/or Disclose Health Information

Date:_____

Patient Name:_____

Address:_____

1. I authorize the use or disclosure of the above named patient's health information as described below.

2. Affinity Health Center is authorized to use and/or disclose the health information.

3. The type and amount of information to be used or disclosed is as follows (e.g., treatment records, prescription records, all information about the patient to date, etc.):

a) Medical and/or other pertinent information needed for coordination and monitoring of service and medical care.
b) Billing and/or insurance information.

4. This information may be disclosed to and used by the following individuals or organizations (include specific information to identify individuals or organizations, e.g., address):
Pediatric Patients- Please list anyone other than the patient's Mother or Father (or Legal Guardian) that may bring the patient to the medical clinic to receive care:

_____

_____

_____

5. **The information will be used/disclosed for the following purpose(s)** (all purposes must be listed. If patient is initiating the authorization, purpose may be described as "At the request of the patient):

a) To coordinate patient care.
b) Communication needed for explaining and/or reviewing medical bills and/or insurance payment information.

6. This authorization permits the use and disclosure of health care information for marketing purposes as described above. NO __X____ YES _____.

7. If the answer to 6 is YES, Affinity Health Center WILL _____ WILL NOT __X__ receive remuneration from a third party for the use of this information.

8. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Affinity Health Center Privacy Officer or his/her designated person. I understand the revocation will not apply to information that has already been released in response to this authorization or that Affinity Health Center has already used or disclosed in reliance on this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: One year from date of initiation.

9. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment or eligibility for benefits where such a condition is prohibited. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. If I have questions about disclosure of my health information, I can contact the Affinity Health Center Privacy Officer at 803-909-6363 or by writing to Affinity Health Center, 455 Lakeshore Parkway, Rock Hill, SC 29730, Attention: Privacy Officer.

10. I understand that, to the extent information about me is disclosed from protected substance abuse records, such information is prohibited from being further disclosed unless further disclosure is expressly permitted by my written consent or as otherwise permitted by applicable law.

Signature of patient or personal representative:_____

If personal representative, give relationship:_____

FOR AFFINITY HEALTH CENTER USE ONLY - To be completed by Affinity Health Center if the above signature is that of a patient's representative.

Affinity Health Center has verified the identity of _____ **[insert patient's representative name]** by_____ **[describe means of verification, e.g. driver's license]** and that in his/her capacity of_____ **[description of authority to act, e.g. husband, wife, etc.]**, he or she is authorized to act on behalf of the patient.

Signature of Affinity Health Center employee:_____