TREATMENT/PAYMENT AUTHORIZATION FOR TREASURE COAST COMMUNITY HEALTH CENTERS, INC (TCCH)

**Please initial next to each line to show that you have read and consent to each statement

1. _____ I give consent and request TCCH to provide me and/or my family with health care**. I acknowledge my responsibility to pay for that care according to the fees established. I have informed TCCH of all insurance coverage. I understand that I am responsible for all charges and fees for my care, except any that are covered by insurance accepted by TCCH. I understand that payment, including co-insurance, co-pays and self-pay/sliding fee payments, is due at the time of service.

2. _____ **HEALTH CARE RELEASE–**I give consent for release of routine medical record information for the purposes of reimbursement, arranging referrals or other health care. I also allow TCCH to release immunizations records to any school or day care.

3. _____ I give permission for my Protected Health Information (PHI) to be disclosed for the purpose of coordinating health care needs, communicating results, and care decisions to the friends and/or family members listed below (***Initial if applicable***)

Name	Relationship	Contact Number

4. _____ I give permission for the individuals listed below to accompany my minor child_____(Child's Name) to TCCH. This will allow TCCH to treat the child, discuss the minor's care and PHI, such as treatment plans, appointments, etc. (***Initial if applicable***)

Name	Relationship to Patient	Contact Number

5. _____ **CARE COORDINATION –** I give consent for coordination of my health care with home and community-based providers of clinical services to also include the chronic care management program.

6. _____ **ACCESS –** I give my consent to access my history from other places (e.g. Pharmacies, Lab Vendors, Accountable Care Organizations), electronically for the purpose of my health care.

7. _____ **PATIENT PORTAL –** I have the opportunity to gain 24 hour access to the Patient Portal. I will keep my sign-on and password safe and access only the accounts I have the right to look at.

8. _____ **TEXT/EMAIL –** I give my consent to receive appointment reminders and other healthcare communications/information from TCCH

9. _____ **I HAVE BEEN OFFERED AND/OR RECEIVED THE NOTICE OF PRIVACY PRACTICE**

THIS CONSENT WILL STAY IN EFFECT FOR TWELVE (12) MONTHS FROM THE DATE SIGNED.

You have the right to amend or revoke this consent at any time.

Signature of: _____

(Circle One) Patient Parent Guardian Date

TCCH Staff Member: _____ Date: _____

**Health Care – Medical, Dental and/or Behavioral Health