MetroHealth

Multidisciplinary and Integrated Healthcare

Client Consent to Treatment and Acknowledgements

GENERAL POLICY: All clients shall be treated, admitted, and assigned accommodation without distinction to race, religion, color, national origin, sexual orientation, age, or handicapping condition.

CONSENT TO TREATMENT: I have come to MetroHealth (MH) for primary medical, nutritional, and/or behavioral health treatment. I ask the professionals at the Clinic to provide care and treatment for me and I will consent to routine tests and other treatments as part of this care plan. I understand that I am free to ask questions about any care, treatment, or medicine that I am to receive. Because MH is a non-profit clinic, I understand that the treatment team will be made up of clinical personnel and students. Clinic personnel include, but are not limited to, medical doctors, nurse practitioners, nutritionists, psychiatrists, licensed clinical social workers, nurses, technicians, interns, residents, and fellows. I am aware that the practice of medicine is not an exact science and acknowledge that no one has given me any promises or guarantees about the result of any care I am to receive or examinations I am to undergo.

I CONSENT TO LABORATORY STUDIES (HIV, HBV, HCV) IN THE EVENT A HEALTHCARE WORKER IS EXPOSED TO MY BLOOD OR BODY FLUIDS.

PROGRAM EVALUATION: I understand that demographic, treatment progress, and other testing information will be gathered about me for the purposes of program evaluation for funding sources, but that nothing will be able to identify me as a client of MH.

RELEASE OF INFORMATION: MH is authorized to release any information necessary, including copies of my clinical and medical records, to process payment claims for health care services which have been provided, and to duly authorize local and federal agencies and accrediting bodies as required or permitted by law. Such records may include information of a psychological and psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer, or person otherwise responsible for payment to provide MH information necessary to determine benefits or process a claim. I release and forever discharge MH, its employees and agents, and my primary care provider from any liability resulting from the release of my clinical or medical records or information from them for payment purposes.

NOTICE OF PRIVACY PRACTICE

A copy of MH Notice of Privacy Practices has been made available to me and I understand that it is there to protect my personal health information. I have had the chance to ask questions about it and feel comfortable with the protections that it offers me. I understand that there are times when my personal health information may be shared, as the law allows, such as: if I am a danger to myself or others, if there is suspected child or elder abuse, and the mandatory reporting of certain diseases.

PATIENT RIGHTS AND RESPONSIBILITIES AND CLIENT GRIEVANCE PROCEDURE

A copy of MH Patient Rights and Responsibilities has been made available to me and I understand that both the Rights and the Responsibilities laid out in that document must govern my interactions at MH. I also understand that both I and MH will be held accountable if those Rights and Responsibilities are

violated. The process by which I may file a complaint against MH is a Grievance. I understand that I have a right to file a Grievance and information about the Grievance process has been provided to me.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS: I assign any and all insurance benefits payable to me to MH. I understand that I am responsible for payment for services rendered at the Clinic, including those services excluded by my insurance either because the plan deems such services not medically necessary, or for any other reason including pre-certification requirements, second opinions, or preexisting conditions. Should the account be referred to any attorney or collection agency for collections, I understand that I will be responsible for attorney or collection fees. I give my permission to my insurance provider(s), including Medicare and Medicaid, to directly pay MH for my care instead of paying me. I understand that I am responsible for any health insurance deductibles, co-insurance, and non-covered services.

I understand that I have the right to revoke this consent to treatment and release of information at any time by submitting my request in writing to MH.

I, the undersigned, state that the information that I have provided MH is true and correct to the best of my knowledge. I acknowledge by my signature, that I have read, understood, and received a copy of this statement. I understand that by my signature, I am agreeing to all of the terms specified herein.

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Client Signature

I CONSENT TO VIEW PRESCRIPTIONS FROM EXTERNAL SOURCES (signature below): MH uses an electronic health records system. Part of this system is E-Prescriptions. E-Prescriptions, or Electronic Prescriptions, are computer-generated prescriptions created by your provider and sent directly to your pharmacy. MH participates in E-prescribing because we care about your health and well-being and E-prescribing has multiple safety benefits. To enable full functionality of the system, MH is authorized to enable external prescription databases. Once the system is enabled, authorized MH employees will be able to view prescription information from external sources.

I agree that MH may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

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Client Signature