COMMUNITY HEALTH SERVICE INC

Consent

Pt ID: _____

No-Show Policy

Initials

I agree that I have reviewed a copy of CHSI's No-Show policy. I understand that it is my responsibility to notify CHSI no later than one business day in advance to cancel or reschedule my appointment. I understand that when I have three no-show appointments within 12 months, I will no longer be able to schedule an appointment for a period of 12 months. I understand that during the 12-month period of not being able to schedule an appointment, I will still be able to receive healthcare as a walk-in only.

Financial Agreement

Initials

I hereby give authorization for payment of insurance benefits to be made directly to CHSI for services rendered. I understand that I am financially responsible for all charges. I certify that the information I have reported regarding my insurance coverage is correct. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits from my insurance carrier. I further agree that a photocopy of this agreement shall be as valid as the original.

HIPAA Signature

Initials

I acknowledge that I have reviewed the CHSI Patient Bill of Rights and Notice of Privacy Practices. I understand that I may ask questions and receive a copy upon request.

Initials

I consent to have my photograph taken for inclusion in the clinic's electronic medical record system for identification purposes. I understand that my photograph will not be released to outside parties without my written consent.

Initials

I authorize CHSI to send appointment reminders electronically via phone or text message to the phone number provided by me at the time of registration and to any family member/dependent associated with the phone number. I understand that this service is offered free of charge, however, standard text messaging rates from my mobile carrier may apply. (Contact your carrier for pricing plans and details)

Authorization to treat

Initials

I hereby authorize any medical, dental, or behavioral health services including services provided with telemedicine services considered by CHSI and its contracted medical, dental, and behavioral health providers to be in my best interests or in those of my family members. I also authorize the release of information acquired during my registration and examination for purposes of payment, treatment, and other healthcare operations. This includes records pertaining to mental health, alcohol/drug abuse, HIV testing, and AIDS-related illnesses.
This includes a medication history review by the provider and pharmacy.

☐ Explained and declined telehealth

I understand that I may revoke this authorization, in writing, at any time. It is understood that CHSI is released from all legal responsibility that may arise from the above acts.

Authorization for care must be signed by the client or his/her parent or legal guardian for clients under the age of 18.

Patient Signature: _____ Date: _____