Crossroad Health Center Consent to Treat Acknowledgement & Authorization

****Please sign and date each item below. Additional information on each section is provided on the next page****

1) I have read and understand the HIPAA/Privacy policy and consent for Crossroad Health Center to provide medical care.

Signed _____ Date: _____
Signature of Patient (if 18 years old or older) or Legal Guardian if patient is a minor

2) I have either received a copy of the Crossroad Health Center Notice of Privacy Practices or declined a copy. Note: The full Crossroad Health Center Notice of Privacy Practices is available on the website.

Signed _____ Date: _____
Signature of Patient (if 18 years old or older) or Legal Guardian if patient is a minor

3) I have read and understand the Financial Policy for Crossroad Health Center. I hereby assign my insurance benefits to be paid directly to the healthcare provider and authorize Crossroad Health Center to release medical information required to process my claim.

Signed _____ Date: _____
Signature of Patient (if 18 years old or older) or Legal Guardian if patient is a minor

4) I have reviewed and accept Crossroad Health Center's no show policy.

Signed _____ Date: _____
Signature of Patient (if 18 years old or older) or Legal Guardian if patient is a minor

5) I authorize Crossroad Health Center to have access to my medication history.

Signed _____ Date: _____
Signature of Patient (if 18 years old or older) or Legal Guardian if patient is a minor

* I authorize to be contacted the following ways: Please check all that apply.

☐ Voicemail: _____

☐ Email: _____

☐ Home Phone: _____

☐ Cell phone/text: _____

Confidentiality Request

I authorize Crossroad Health Center to discuss all lab results and medical information to the person/persons listed below:

Full Name:_____ Relationship:_____ Phone #:_____

Full Name:_____ Relationship:_____ Phone #:_____

Crossroad Health Center Consent to Treat Policies

1) Consent to Treat

I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to, physical examination, administration of medications, blood draws, diagnostic tests, laboratory test, and other minor procedures) to be performed by office personnel, including physicians, nurses, and assistants.

Health Information Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that provides protection for your personal health information. I acknowledge that:

1. My personal health information can and will be used by Crossroad Health Center, as necessary, for treatment, to obtain payment for this treatment, and for the health care operations of the practice (this authorization includes release of information concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychological conditions, and/or HIV related conditions);
2. My personal health information will be disclosed to other Crossroad Health Center affiliates for the purpose of furthering my treatment;
3. My physician will warn the appropriate authorities and/or other individuals if he/she determines that I am a harm to myself or to others;
4. My picture or other type of recording may be taken by employees or providers of Crossroad Health Center for reasons including, but not limited to, patient identification, assistance in diagnosis/treatment, documentation of conditions present upon arrival, and practice internal purposes.

Telehealth Notice

I understand that Crossroad Health Center may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

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2) Notice of Privacy Practice (NPP)

One of the requirements of HIPAA is that we give you a Notice of Privacy Practices that describes your rights and protections regarding your personal health information. You have the right to review our NPP before signing this consent *(Crossroad Clinical Manual - Policy 1.35 - Patient Rights*

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3) Payment and Insurance Reimbursement

Crossroad Health Center will bill your insurance company (including Medicare) for services provided. Crossroad Health Center DOES NOT accept responsibility for collecting or failing to collect insurance claims, and you acknowledge that you are responsible for payment for any services provided and that you will pay any and all charges due and owed to Crossroad Health Center (including any co-pays and/or deductibles).

Crossroad Health Center and the physicians providing services to you will initiate payment of your claims for benefits (and may also process appeals from decisions related to your claims and benefits). In order to do this, it is necessary for all responsible parties to give us certain rights and permissions:

1. I (as patient or as agent of the patient) hereby assign and transfer all rights of third party payor benefits for services rendered to me to Crossroad Health Center and/or its physician(s) and authorize any insurance or third party payments to be made directly to Crossroad Health Center and/or its physicians.
2. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, or under the terms of any other carriers, is correct. I request that payment of authorized benefits be made on my behalf pursuant to the above assignment. I assign the benefits payable for covered Medicare services and any other services to the physician(s) and/or organization(s) furnishing the services and authorize such physician(s) and/or organization(s) to submit a claim to Medicare or other third party payer for payment. Any asssignment of benefits is limited to the Medicare allowed charge for physician services or to an amount not to exceed Crossroad Health Center's regular charges.
3. I understand that in consideration of the services to be rendered, I am responsible for payment for any services not covered by third party payers, and I will pay any and all charges due and owering Crossroad Health Center, its subsidiaries, and/or its physician(s) in accordance with their regular rates, terms, and policies.

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4) Patient Appointment Late Arrival and 'No Show' Policy

- I will notify Crossroad Health Center if I cannot keep my appointment.
- If I have to cancel my appointment, I will do that at least 24 hours in advance.
- If I do not cancel my appointment at least 3 hours ahead of my scheduled appointment, I will be considered a 'no show'.
- If I arrive 15 minutes late for my appointment, I may not be able to see the provider or may have to wait until the provider has time to see me later that day.
- If I am late for or miss 3 appointments in a 6 month period, I may be dismissed from Crossroad Health Center or only be able to schedule same day appointments.