East Texas Community Health Services, Inc.
Consent for Treatment

I hereby and voluntarily consent to authorize the Center's healthcare providers, including its physicians, midlevel providers (Physician Assistants, Advance Practice Nurses) and dentists at their service locations to provide health care services to me. The health care services may include, without limitation, routine physical and mental assessment, diagnostic and monitoring tests and procedures, examinations and medical and/or dental treatment, routine laboratory procedures and tests (such as blood, urine and other studies), x-rays and other imaging studies, heart tracing (EKG), administration of medications, as well as procedures and treatment prescribed by the Center's medical and/or dental Staff. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations).

I understand that I will be asked to sign a separate informed consent for each vaccine to be administered to me and that I will receive a "Vaccine Information Statement" (VIS) prior to receiving each vaccine. I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions, HIV testing and/or specific procedures.

I understand that there are no guarantees being made to me concerning the results of the treatment provided or the effectiveness of any birth control methods prescribed for me.

I understand that this consent is valid and remains in effect as long as I am a patient of the Center.

Consent Provisions

My signature on this form indicates that: (1) I acknowledge that the informed consent for medical treatment and/or procedures ("Treatment") at the Center has been adequately explained to me by the Center's Physician, Physician Assistant, or other qualified Healthcare Provider; (2) I have received all of the information that I desire concerning the Treatment; (3) I have had the opportunity to obtain answers to my questions concerning the nature of the Treatment, its expected benefits, potential discomforts/side effects/risks, and any and all alternatives (and their risks and benefits), and the consequences of not receiving Treatment; (4) I understand that as with all medical treatment, there is a possibility that complications other than those described to me or in this form may occur, and that no guarantee is made regarding the outcome of my Treatment; (5) I realize that although every effort will be made to keep all risks and side effects to a minimum; risks, side effects, and complications can be unpredictable both in nature and severity; (6) I understand that "Midlevel Providers" (Physician Assistants, Advance Practice Nurses) will be involved in my Treatment and I consent thereto; (7) I have carefully read and understand the information presented to me and in this informed consent form; (8) I hereby voluntarily give my consent to Treatment at the Center; (9) I understand that I may be asked to sign a separate informed consent form for certain Treatment(s) that require a separate informed consent form; (10) I acknowledge that I have been fully informed of my right to receive a copy of this signed and dated informed consent form, and (11) I realize my signature authorizes the contractor to view the client's BCCS clinical services/data history stored in Med-IT or an electronic medical record (EMR).

Name of Patient: _____ Date of Birth: _____

Signature:_____ Date/Time: _____a.m./p.m.

Print Name: _____

Relationship to Patient: □ Self □ Parent □ Guardian □ Other: _____

Signature of Witness:_____ Date/Time: _____ a.m./p.m.

Print Name of Witness: _____

EAST TEXAS COMMUNITY HEALTH CLINICS

Patient Acknowledgement of Notice of Privacy Practices and Psychiatry Addendum Patient and Center Rights and Responsibilities

I acknowledge I am aware of and may request a copy of the:

- Notice of Privacy Practices of *ETCHSI* (dated 9-2013)
- Notice of Privacy Practices, Psychiatry Addendum of *ETCHSI* (dated 9-2013)
- Patient and Center Rights and Responsibilities (dated 2012)

Print Patient Name: _____ Date: _____

Signature of Patient/Parent/Guardian: _____

Print Name of Parent/Guardian and Indicate Relationship to Patient:

_____

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained

_____

_____

Staff Signature: _____ Date: _____

Print Name: _____ Title: _____

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Insurance Benefit Assignment and Authorization to collect and release Insurance Information for Billing Purposes

I hereby authorize my insurance benefits to be paid directly to East Texas Community Health Services, Inc. (ETCHSI), and I understand that I am financially responsible for co-pays, un-met deductibles and non-covered services.

I further authorize ETCHSI to release any information required by the insurance carrier.

Patient/Guardian Signature:_____ Date:_____

Patient ID: _____

Veteran? Yes_____ No_____
US Citizen? Yes_____ No_____