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 and have provided copy of all insurance cards. 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 my Protected Health Information (PHI) to be captured by a virtual or live Medical Scribe for the purpose of coordinating health care needs, communicating results, and care decisions. This Information may be recorded for quality-control purposes and accurate data entry into your permanent medical record. Any records would be temporary and deleted after entry into the permanent medical record. All information transcribed will be reviewed and verified by your Healthcare Provider.

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/VOICE –** I give my consent to receive appointment reminders and other healthcare communications/information from TCCH

9. _____ I hereby grant permission to TCCH to use photographs of me or my child taken on _____ at TCCH for identity purposes **ONLY**."

10. _____ **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