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. 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)*

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Contact Number</th>
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4. ________ I give permission for the individuals listed below to accompany my minor child _____________________ (Child’s Name) to TCCH. This will allow TCCH to treat the child, discuss the minor’s care and PHI, such as treatment plans, appointments, etc. *(Initial if applicable)*

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Patient</th>
<th>Contact Number</th>
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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 – I give my consent to receive appointment reminders and other healthcare communications/information from TCCH

9. ________ 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**

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