CALLEN-LORDE

MR#:_____

PATIENT CONSENT FORM

_____
Please initial

CONSENT FOR TREATMENT:

I am voluntarily seeking medical care and treatment from Callen-Lorde Community Health Center ("Callen-Lorde") and give permission to the medical, mental, and oral health staff of Callen- Lorde to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations, and recommendations they provide me.

_____
Please initial

CONSENT TO BILL:

If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will plan to pay or be billed for any outstanding balances in accordance with Callen-Lorde's Patient Financial Policy.

If my insurance is accepted, I authorize payment of benefits to Callen-Lorde or will reimburse Callen-Lorde if I am paid directly by my carrier. I understand that my insurance may not cover all charges deemed medically necessary by Callen- Lorde and that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

I hereby authorize that Callen-Lorde may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy.

I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory.

CONSENT FOR RESEARCH STUDIES:

To better serve our patients, Callen-Lorde regularly conducts research studies on health care, health disparities, and potential health interventions. Please choose one of the options below; the choice you make will NOT affect your ability to get health care services at Callen-Lorde.

Please initial one of these two

☐ ***I GIVE CONSENT*** for Callen-Lorde to contact me (including via phone, text, or e-mail) about research studies. *(Choosing this does not enroll you in any study and you can withdraw your consent to be contacted at any time.)*

☐ ***I DENY CONSENT*** for Callen-Lorde to contact me about research studies.

_____
Please initial

PATIENT RIGHTS AND RESPONSIBILITIES:

I have received a copy of the Callen-Lorde Patient Rights and Patient Responsibilities

_____
Please initial

PATIENT HIPAA NOTICE PRIVACY PRACTICES :

I acknowledge that I have received a copy of the Callen-Lorde HIPAA Notice of Privacy Practices.

This signature acknowledges all of the above as initialed. I am aware that Callen-Lorde may or may not contact me based on the above indicated consent choice regarding research studies I may be eligible for.

_____ X_____ ____/____/____

Patient Name (please print) ***Patient Signature*** ***Date***

If this page is being signed by a personal representative, please fill out the information below:

_____ X_____ ____/____/____

Personal Representative Name (please print) ***Signature of Personal Representative*** ***Date***

Authority of Personal Representative to Sign for Patient (**check one**): □Parent □Guardian □Power of Attorney □ Other: _____