Patient Name:_____ **Patient Date of Birth:**_____

Consent to Treatment & Acknowledgment of Receipt of Information

Welcome to CrescentCare! We are a Federally Qualified Health Center (FQHC) providing a variety of services including Primary Medical Care, Mental Health Care, Dental Care, Women's Health and Pregnancy Care, Specialty Care for HIV and other Infectious Diseases, Child and Adolescent Care, Behavioral Health Counseling, Case Management, HIV Counseling & Testing, Substance Use Disorder Treatment and Counseling, Housing Support, Medication Assistance, Health Education, and other various client services including Legal Services, which are available to eligible individuals who participate in CrescentCare's Primary Care Medical Home (PCMH). Some programs have additional eligibility requirements due to funding. We look forward to putting your needs at the center of our planning and opening the doors of our Medical Home to you and your family.

____ ***Consent to Participate***: I understand that health care delivery is not an exact science, and I acknowledge that no guarantees have been made concerning results of my care at CrescentCare. At the discretion of my provider, telemedicine (audio/video and/or audio only) may be provided and I will have the opportunity to decline to receive care using that option. If I am prescribed a controlled medication, I agree to abide by the requirements of the most recent CrescentCare Controlled Medication Agreement and I have been offered a copy of that document. I can ask for another copy at any time or find it on the CrescentCare website.

____ ***Consent to Access and Disclose Release Medical Information***: I also authorize CrescentCare and its employees to act as my *(the patient's)* authorized representative when providing me with benefits application assistance. I hereby authorize, without further consent, CrescentCare and my practitioner to release minimally necessary information if requested by my health insurance company, Medicare, Medicaid, and any other third-party payer or its designees for service reimbursement. I authorize, without further consent, CrescentCare and my practitioner to release and/or receive minimally necessary information requested by any department or person within the Agency for business reasons or for the purpose of providing services to me or coordinating my continuity of care. I consent to have my practitioner obtain my medications history electronically.

____ ***Financial Agreements***: CrescentCare's policy is to provide essential services regardless of my ability to pay. CrescentCare utilizes sliding fee schedules for services it provides that are consistent with locally prevailing rates or charges and which are designed to cover the reasonable costs of the organization's operation. When I am referred to an outside provider, I must make payment arrangements with them separately. If I have any questions about the sliding fee scales or billing, I can contact CrescentCare by emailing billing@crescentcare.org and/or by calling the Billing Department at 504-323-2638.

_____***Consent for Billing and Financial Obligations:*** If private health insurance, Medicare, Medicaid, other governmental or other insurance programs cover my treatment, I authorize CrescentCare to bill any such insurer for all charges incurred by me in connection with my diagnosis, care and treatment. My insurance coverage may provide that some amount of the bill will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered by my health insurance, Medicare, Medicaid or any other programs for which I am eligible. I understand that will be billed for any charges not paid by my insurer, and I will be responsible for paying them. I understand that if I have Medicare coverage, it is likely that Medicare will pay for the services I receive. CrescentCare will provide me with an estimate for any items which Medicare is not expected to pay, as well as the reason for their denial. Any charges not covered by insurance, including Medicare, will be my responsibility.

____ ***Assignment of Insurance Benefits***: I hereby authorize and instruct my insurance company to pay any and all medical and/or other benefits directly to CrescentCare. I further hereby assign and set over to CrescentCare all my rights, interests, and benefits payable under any plan or policy under which I am entitled coverage concerning services rendered.

____ ***Communication***: I agree to receive communications from CrescentCare including mail, e-mail, phone calls or text messages related to billing, care and treatment, appointment reminders, and quality of care surveys. It is my responsibility to tell the Agency about any method that I don't want to receive. A Patient Access or Call Center staff can assist me with changes.

_____ ***Team Approach:*** CrescentCare providers and staff work collaboratively with each other, when appropriate, to ensure your care is coordinated. CrescentCare's goal is to provide you with a personalized support network where you and all of your providers collaborate in the treatment process to achieve your desired results. I authorize CrescentCare providers and staff involved in my care to access my medical record and discuss my medical conditions, including any substance abuse treatment I may receive at CrescentCare with each other and others, as appropriate, in the furtherance of providing me quality health care or coordinating my care and services outside of CrescentCare.

____ ***Receipt of Documents***: You have been offered and/or received the *CrescentCare Notice of Privacy Practices (HIPAA)* & *Patient & Client Handbook*. These documents contain detailed information on payment/financial agreements for services, use of health insurance, confidentiality, all CrescentCare services available, your rights and responsibilities, safety on the premises (drug use, weapons, smoking, seclusion/restraint, crisis prevention, evacuation), our grievance policy, how we communicate with you about appointments, payment practices, and our locations/hours of operation. You can also access these documents on the CrescentCare website.

____ ***Health Information Exchange (HIE)***: CrescentCare is a participating member of several health information exchanges. A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. You authorize CrescentCare to share your healthcare information with and to receive my healthcare information from those exchanges. This information may be accessed by another participating provider as part of a normal office visit or in case of an emergency if you were to go to the hospital, emergency room. You have the right to opt-out of participating in any and all HIEs. This authorization may be revoked in writing at any time except to the extent that actions were taken before the revocation. You understand that you may be responsible for charges incurred for services/treatment if you refuse to share your medical record between participating providers or if you later revoke this authorization, either of which could result in a denial of payment by the insurance or third-party claim payor for medical non-necessity of services. Your consent to participate or your refusal to participate in any HIE is not a condition for treatment at CresentCare. You can request an Opt-Out form at any CrescentCare location from at the Patient Access front desk. Any questions or concerns can be communicated to the CrescentCare Privacy Officer by calling 504-821-2601 or emailing privacyofficer@crescentcare.org.

My signature below constitutes my acknowledgment and agreement that I have read (or had read to me) and I understand the information I was given. I was given the opportunity to discuss this form and ask questions, all questions were answered to my satisfaction, and I am satisfied that I understand the form's contents andsignificance. ***I certify that I have read this form and either am a participant or am duly authorized by law to execute the above and accept the terms.***

_____ _____
Name of Patient Patient Date of Birth

_____ _____
Signature of Patient or Authorized Individual Today's Date

If Authorized Individual, **please print** your name and relationship to patient:

_____ _____
Name Relationship to Patient

For Internal Use Only: Please use this box to detail any information related to the completion of this document.

_____

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_____

Patient Access or CrescentCare StaffName: _____

Patient Access or CrescentCare Staff Signature & Date: _____