ADULT & MINOR
CONSENT TO TREATMENT/TELEHEALTH CONSENT

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Patient Name -PRINT

I hereby consent, for myself or for whom I am legally responsible for, to receive outpatient services provided by Boston Mountain Rural Health Center, Inc. ("BMRHC"), including, but not limited to the examination, diagnosis, and treatment. I understand that this consent remains in effect so long as I am a patient of BMRHC, and I understand I may discontinue services at any time.

Our center requires that a parent or guardian give specific permission if a minor child will receive treatment when the child is accompanied by someone other than the parent or guardian. When a parent or legal guardian is not immediately available and advanced consent has not been provided, emergency care will not be delayed, but verbal consent and authorization will be required as quickly as possible for treatment.

Complete for Minor, if applicable:

If I am unable to be present for my child's visit, the person(s) listed here is/are authorized by me to accompany my child to their visits and sign any necessary consents or acknowledgements on my behalf, including responsibility for payment. **I understand that individuals that accompany my child Must be 18 or Older.**

Name: _____________________________**Relationship:** __________________**Contact#**______________________

Name: _____________________________**Relationship:** __________________**Contact#**______________________

Complete for School Based Health Centers:

As the parent/guardian, I grant permission for school personnel to transport and/or accompany the above named student to BMRHC visits and as with other health related matters, health information cannot be released without consent. If sports physicals are completed, I give consent to release to my child's school.

Telehealth/Video Conference Services

I have received a copy, read, and understand the telemedicine guidelines. I agree to participate in the telemedicine consult, in which my image and my Protected Health Information (PHI) will be transmitted electronically through the videoconference(s) to health care professionals that are authorized to receive such information for the purpose of providing medical diagnostic assessment and treatment services.

I understand that the software system is encrypted, so the likelihood of this transmission being intercepted by unauthorized persons is EXTREMELY small. I understand that I can withdraw my permission at any time prior to the videoconference and/or my interrupt the videoconference at any time. In either case, I understand that no action will be taken against me, and I may still pursue a consultation in person with a physical or other health care professional. I also understand that if I interrupt the videoconference, the consultation will be incomplete. Therefore, I understand that health care professionals involved in the video conference will be unable to provide treatment or services to me at that time.

I understand that there are limits to Telemedicine Technology. Therefore, there is no guarantee that this Telemedicine session will eliminate the need for me to see a specialist in person in order to receive appropriate or additional treatment for my current condition.

Notification of Privacy

I have received a copy, read, and understand the BMRHC Notice of Privacy Practices. Please be aware that BMRHC's behavioral health services are designed to provide treatment only. Treatment services offered must be medically necessary. Copies of Independent Licensed Practitioner (ILP) and behavioral health service rules are available to patients upon request.

Authorization to Release Information

I hereby authorize BMRHC to release any necessary information acquired in the course of my examination or treatment to any authorized agent related to treatment, payment, or healthcare operations. I further authorize the ability to view prescriptive history from external sources. I further authorize the release of health information to federal and state governing entities for the purposes of required reporting.

Authorization to Pay BenefitsI authorize the clinic to release medical, dental, behavioral health or other such information to the third party insurance carriers for the purposes of filing insurance claims related to my care and understand that I may be billed for services rendered

.**<u>Acknowledgement</u>** I acknowledge that I am responsible for the payment of the account balance. I understand that third party service payments may be denied based on the third-party payer's policies and rules. I agree to be responsible for all amounts not covered by my insurance.

By signing below, I am acknowledging that I am the patient or the authorized representative for the patient.

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Patient Signature or Designated Representative (If minor, Parent or Legal Guardian Date