Athena ID: _____

Consent for Services

Patient Name: First _____ Middle _____ Last _____

Date of Birth: _____ / _____ / _____ Gender: [ ] Male [ ] Female

Consent for Treatment: By this document, I do hereby request and authorize Southwest District Health (SWDH), its staff, family medical clinic and providers including physicians, other practitioners, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary, and other services that are deemed necessary, advisable, or beneficial by the providers to effectively diagnose and treat me. I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations, or procedures.

Release of Information: I authorize the release of any medical information necessary for the purposes of treatment, health care operations and to obtain payment from my insurance company, Medicare, Medicaid, other physicians or providers, and any other third-party payers. I understand that my health information may be shared across the SWDH programs, including dental, medical, epidemiology, family health, behavioral health, and community health.

Authorization to Bill Insurance and Assignment of Benefits: I authorize SWDH to directly bill my insurance company and any third-party payer through which I have benefits to make payment directly to SWDH. I authorize SWDH or insurance company to use and disclose any healthcare information to obtain payment for services and determining insurance benefits. I understand that I am financially responsible for any balance. Services provided by outside companies, (i.e., lab, pathology) are billed separately by those companies.

Electronic Health Record: I understand that SWDH is a member of the Idaho Health Data Exchange (IHDE), a secure internet-based health information exchange for improving quality coordination of health care in Idaho. I understand I may "opt out" from the IHDE by completing a Requests to Restrict Disclosure of Health Information and submitting it directly to IHDE by mail or fax or am able to contact IHDE at (208) 803-0030.

Electronic Prescribing: I understand that SWDH family medical clinic and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my SWDH providers and my pharmacy. I have been informed and understand that SWDH providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my SWDH providers to see this health information.

Consent for Virtual Health/Telemedicine Services: I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand I may withdraw my consent at any time.

Immunization Registry: I understand that SWDH participates in Idaho's statewide immunization registry, Immunization Reminder Information System (IRIS). The registry is a secure internet-based system that complies with federal health information privacy laws. I do hereby grant permission for SWDH to send or fax childhood immunization records to schools, upon request. IRIS is a voluntary system. If you would like to opt-out of this program, please contact the Idaho Immunization Program either by phone at 1-208-334-5931 or by email: IIP@dhw.idaho.gov.

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Financial Agreement: I acknowledge that as a courtesy, SWDH may bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. If I do not have insurance and qualify for a sliding fee program, my copay for services will be expected at time of my visit. If I fail to make full payment or fail to comply with other payment arrangements made with SWDH's approval, I understand that appropriate collection measures may be initiated and that I am financially responsible for all charges, late fees, interest, attorney fees and collections charges considered patient responsibility.

Notice of Privacy Practices: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of SWDH's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices.

Consent to Communication: I consent and authorize SWDH staff and providers to contact me via the methods selected below to communicate information including appointments, billing, patient portal, prescriptions, test results, follow-up care instructions, other relevant health information, and marketing: ***(Check all that apply)***

[ ] Phone call _____ **[ ] Voicemail** _____

[ ] Text message _____ **[ ] Email** _____

[ ] I DO NOT consent to receive communications

Optional: I authorize the person named below to receive my medical information or call in for me if I cannot be reached by my provider or other staff.

_____	_____	_____
Name	Relationship to Patient	Phone Number

Acknowledgements:

I have been given access to, and may have a copy of, the SWDH Patient Rights and Responsibilities.

I certify the information provided here is true, complete, and accurate. I certify that I have read and understand this verification of informed consent for general care and treatment and statement of financial responsibility. I will promptly notify SWDH of changes in insurance, family income or size.

I declare under penalty of perjury under the laws of this state that the foregoing information is true and correct.

_____	_____
Signature of Patient or Parent/Legal Guardian	Date
_____	_____
Printed Name	Relationship to Patient