Consent Form

Place Label
Here

Consent for Care:

Consent will not expire until the Clinic is notified in writing that you wish to revoke.

At Health*First* Bluegrass (HFBG) it is our goal to assist patients in finding their greatest level of wellness. To do so, our provider teams consist of a variety of professionals who work together to improve both physical and emotional health. Regardless of specialty (medical, dental, and behavioral), HFBG provider teams will communicate patient information when clinically necessary.

I give my consent for ______________________________ ________________ ______________

PATIENT'S FULL NAME **DATE OF BIRTH** **SOCIAL SECURITY #**

To receive any of the following services at Health*First* Bluegrass, Inc.:

1. Treatment may include screening, exams, lab tests, treatment, medicine, behavioral services, and any other studies or procedures that Health*First* Bluegrass professional staff decide are necessary or appropriate.
2. Medical evaluation at Health*First* Bluegrass may also include testing for HIV infection, Hepatitis B, or any other disease carried by blood or body fluids. These tests may be needed for diagnosis; to assist in your medical treatment, or if a health care worker is exposed to your blood, body fluids or tissue.

I give consent for Health*First* Bluegrass, Inc. staff to:

1. Obtain and/or share information and records from outside facilities including primary care practices, specialists, hospital systems, agencies, private professionals, etc.in order to provider appropriate care. HFBG is released from all liability that may arise from the release of such information.
2. Request medication history in the last 2 years through our electronic health record system.
3. Use telemedicine equipment with the service provider being located offsite. These sessions use secure, dedicated high-speed lines in accordance with applicable law, regulations, and guidelines. They are not videotaped, routed through the internet or saved in any way.

In accordance with Federal and State laws, certain types of records that are obtained and/or shared may require an additional release before health information, including psychotherapy notes, can be released.

Electronic communication:

1. Is it okay for HFBG to use an automated telephone message to remind you of your appointment (only a time, date and location will be stated)? **Please initial** **Yes_____No ____**
2. Is it okay for HFBG to contact you with appointment reminders and general communications using text messaging and/or e-mail? **Please initial** **Yes_____ No _____**

HFBG will use your statements, medical history, and other clinical information to evaluate your needs and recommend the best plan of care. No guarantees are being made as to the outcome of any exam or treatment. Please ask your treatment team all questions about risks and benefits of recommended treatments. **I understand that I have the right to and will be given an opportunity to speak to a provider regarding the patient's treatment and any risks.** **Please initial** **Yes____ No ____**

My signature below confirms my identity and shows that I am giving my consent for treatment. If signing for a minor, my signature confirms that I am the parent or legal guardian and am consenting to the minor's treatment. I understand this consent will remain in effect until revoked. To terminate this consent, I must do so in writing.

Signature of Patient, Parent, Legal Agent/Guardian	**Printed Name of Person Signing**	**Relationship to Patient**	**Date**

Phone Number:__________________________ **Email:** ____

Privacy Acknowledgement

I understand that Health*First* Bluegrass shall provide a copy of their Notice of Privacy Practices upon my request.

I understand that Health*First* Bluegrass may release patient information WITHOUT permission if: 1) Patient poses a threat to him/herself or others; 2) The patient is unable to protect him/herself from risk of harm; 3) There is evidence of child abuse, neglect, and/or exploitation; 4) There is evidence of dependent adult abuse, neglect, and/or exploitation; 5) There is evidence of domestic violence; 6) Patient information is requested under court order and/or if a patient willingly enters their treatment history into a court proceeding.

Health*First* Bluegrass may be required to share your information if certain legal conditions are met. Health*First* will only share your information when required by law and will only share the minimum amount necessary. For more information, please see the Health*First* Notice of Privacy Practices Form. Health*First* Bluegrass will release your records to your insurance provider for billing and case management.

Date	**Signature of Patient, Parent, Legal Agent/Guardian**	**Relationship to Patient**

HEALTH FIRST™ BLUEGRASS

Patient's Full Name

Place Label Here

Consent for Payment

I request that payment of authorized medical insurance benefits be made to Health*First* Bluegrass on my behalf for services received.

I authorize Health*First* Bluegrass to release medical information about me to Medicare, KCHIP, Medicaid insurance and other third-party payers to determine payment for service.

I give my consent for all services listed above. I certify that I am of full capacity to execute the above authorization and release. I agree that the completed information is true to the best of my knowledge. This consent does not expire unless revoked.

Date	Signature of Patient, Parent, Legal Agent/Guardian	Relationship to Patient

Media/Photography Consent

I give consent for Health*First* Bluegrass, Inc. to use my or my child's photograph, likeness and/or voice in any way that would reasonably portray Health*First* Bluegrass, Inc. I release Health*First* Bluegrass, Inc. and any of its employees or agents from any damages in using my or my child's photograph, likeness, and/or voice. This includes but is not limited to photographs for the patient's medical record. Your photo will be taken for chart identification. Photos may also be taken for clinical documentation purposes. Photos are housed within your chart.

Date	Signature of Patient, Parent, Legal Agent/Guardian	Relationship to Patient

For Pediatric Patients Only:

School Based Clinics

HealthFirst Bluegrass has several clinics located within elementary, middle, and high schools in Fayette County. HealthFirst Bluegrass School clinics are full-service medical clinics which are open to the community in addition to servicing the students who attend those schools. The goal of the School Based Clinics (SBCs) is to assist in your child's overall well-being. Partnered with FCPS, information sharing of pertinent medical, behavioral, dental and school health will occur between appropriate FCPS staff and SBC staff.

I give consent for my child to receive any of the following services at Health*First* Bluegrass, Inc. School-Based Clinics:

1. Physical assessment of acute or chronic illnesses including assessment of growth and development.
2. Treatment of minor health problems as defined by protocol, including administration of over-the-counter medications.
3. Basic laboratory test (when needed to assess problem) such as a finger stick for anemia and blood sugar, urine test for bladder or kidney infection, throat swab/strep screen for sore throat, etc.
4. Health education and promotion to include education and counseling regarding physical, mental, and sexual health.
5. Dental examination, cleaning & home care instruction (x-rays available as needed).
6. Referrals to outside agencies for services that may not be provided at the SBC.
7. Annual physicals and immunizations with parent/guardian present.

I give consent:

1. To HealthFirst Bluegrass, Inc. staff to review my child's full school record, including attendance and other information that will assist the staff in the continuity of care and treatment of my child.
2. Communicate and disclose pertinent medical, behavioral health, dental, and school health information with appropriate Fayette County School Staff in regard to my child's success at school and in the school setting.
3. Have my child participate in on-going evaluations of the SBC program, including questionnaires and surveys. I understand that my child will not be identified in the evaluation.

Consent for health services at school clinic:

Do you give consent for your child to receive health services without an individualized notification each time prior to receiving treatment or being referred for these services? **Please initial** **Yes____** **No____**

Consent for mental health services at school clinic:

Do you give consent for your child to receive mental health services without an individualized notification each time prior to receiving treatment or being referred for these services? **Please initial** **Yes____** **No____**

Date	Signature of Patient, Parent, Legal Agent/Guardian	Relationship to Patient