Consent to Treatment and Health Care Agreement	Patient Label

CONSENT FOR TREATMENT

I hereby consent to receive health care from CommUnityCare physicians, employees and such associates, assistants and other health care providers as my care team deems necessary. This care may include, but is not limited to, assessments, treatments, examinations, diagnostic or laboratory procedures (which may include HIV testing), administration of injections and/or medications, and other routine medical, nursing or dental care. I understand some services could be provided through Telemedicine, a treatment modality using interactive videoconferencing. I have been informed and understand that this facility is affiliated with a teaching institution and the services performed may require observation, cooperation, and involvement of multiple health care providers. I authorize residents and/or students to participate in my care; however, I have the right to request to see a physician. I understand that I may revoke this consent at any time, except for services I have already received.

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES & PRIVACY PRACTICES

I acknowledge that I have been given a copy of the following:

- **Patients' Rights and Responsibilities** – defines my rights and responsibilities as a patient that receives health care services from CommUnityCare.
- **Notice of Privacy Practices** – provides information about how CommUnityCare and its workforce may use and/or disclose my protected health information for treatment, payment, health care operations and as otherwise permitted by law.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

I hereby authorize and instruct my insurance carrier or other third party payer to submit payment to CommUnityCare for any health care services otherwise payable to me.

I agree to pay all charges for any health care services that are not covered or collected from my insurance carrier or other third party payer, including any deductibles and coinsurance amounts.

_____ _____

Signature of Patient or Authorized Party Relationship to patient

_____ _____

Witness Date