Consent for Outpatient Treatment

This form includes important information about how care is provided to patients at Family Medicine Health Center ("Health Center"). Patients and parents, guardians, and other patient representatives should read this information carefully or ask for assistance to have the form read to you. By signing this form, you agree to receive care at the Health Center according to the following terms and conditions:

1. Consent. I request and authorize the Health Center and its physicians, residents, assistants and designees to provide the medical care and treatment necessary or advisable to me, or the patient identified below. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care.
2. Emergencies. I authorize the Health Center to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my, or the patient's, life or health.
3. Risks and Benefits. I am aware that the practice of medicine is not an exact science and I understand that the Health Center is not making any guarantees or promises about the results of the care received.
4. Health Changes. I understand that it is my responsibility to tell the Health Center if there are any significant change in my, or the patient's, physical or emotional condition.
5. Testing. I understand that samples of body fluids and/or tissues may be withdrawn during tests and procedures. I authorize the Health Center and its affiliates to perform other tests on these body fluids and/or tissues in order to further treatment.
6. Medication Verification. I authorize the Health Center to contact healthcare providers from whom I, or the patient, have received treatment to obtain medical information and/or records, including but not limited to, commercial pharmacies (i.e. Walgreens, CVS, Costco, etc.), and alcohol and other drug treatment records for verification of my medications and treatment.
7. Transmittable Diseases. I have been informed and understand that HIV (human immunodeficiency virus)/AIDS, HCV (hepatitis C virus) and HbsAg (hepatitis Bvirus) tests may be performed on me, or the patient, without my consent if a health professional, facility employee or First Responder sustains an exposure to my, or the patient's, blood or other body fluid.
8. Personal Valuables. I understand that I am responsible for any and all personal valuables that I bring with me, or the patient, to the Health Center. I hereby release the Health Center and its agents from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my, or the patient's, care and treatment.
9. Residency Program. The Health Center is operated by the Family Medicine Residency of Idaho. Health Center patients are cared for by a medical team that includes a physician, a resident and a mid-level provider (PA, NP, and CNM). The physician and resident will be your primary providers. A resident "is a doctor who has received a medical degree (MD, DO) from an accredited medical school and who practices medicine under the supervision of a fully licensed physician, usually in a hospital or clinic". I consent to having a resident and student involved in my, or the patient's, care.
10. Acknowledgement of Privacy Practices. The Health Center's Notice of Privacy Practices provides information about how protected health information about patients may be used or disclosed for purposes of treatment, payment or the Health Center's operations. Information about communicable diseases and infections, including venereal disease, tuberculosis, hepatitis B, HIV (AIDS virus) and AIDS related complex, alcohol and drug abuse treatment information, mental health treatment records, and reports of abuse, abandonment or neglect may be used and disclosed under certain circumstances. I have been offered an opportunity to review the Notice before signing this

consent. I understand that the terms of the Privacy Notice may change and that I may request a current copy from the Health Center at any time.

11. Attendance Policy. A copy of the Health Center's Attendance Policy has been made available to me. I understand it is my responsibility to know my, or the patient's, appointment dates and times and I understand that services may be discontinued in the event I, or the patient, do not attend scheduled appointments.
12. Ending Treatment. I understand that I have the right to terminate treatment at the Health Center at any time I choose to do.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS, AND HAVE THESE QUESTIONS ANSWERED.

_____ _____

Signature of Patient/Legal Guardian Date

Authorization to Bill Insurance, Financial Responsibility, Credit Policy

Authorization to Bill Insurance and Assignment of Benefits. The patient information is true to the best of my knowledge. I authorize FMHC to directly bill my insurance company and I further authorize any third-party payer through which I have benefits to make payment directly to FMHC. I understand that I am financially responsible for any balance. I also authorize Family Medicine Health Center or insurance company to use and disclose any healthcare information for the purpose of obtaining payment for services and determining insurance benefits. Services provided by outside companies, (i.e., lab, pathology, radiology) are billed separately by those companies.

Financial Responsibility. I understand that I am financially responsible for the payment of medical charges incurred on my behalf at Family Medicine Health Center, including charges that are not paid in full by my insurance, government program benefits, or other third-party payers. I also agree to pay or reimburse FMHC for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees. Services provided by outside companies, (i.e., lab, pathology, radiology, durable supplies) are billed separately by those companies.

Credit Policy
PHILOSOPHY: It is the desire of Family Medicine Health Center (FMHC) to provide quality medical and behavioral health services without barriers to access. This policy guides us in providing access to care while also ensuring we collect amounts owed to us for the provision of services. For those patients with insurance coverage, we will properly bill insurance on a timely basis. If you do not have insurance coverage, we are sensitive to your financial constraints and do not want to impede access to care that is vital to your health. FMHC will work with its patients on payment plans to absolve account balances but requires that the patient stay engaged in this process and follows the terms that have been agreed to.

PROCEDURE:
1. We will request payment at the time of service. If you are unable to pay the adjusted amount due at the time of appointment, we will ask that you pay what you can and FMHC will bill you the balance.
2. If you receive an account statement from us and cannot pay the entire balance, we request that you contact us within 30 days about a satisfactory payment plan to resolve the amounts due.
3. If you have not made any payments on your account and have not agreed to a payment plan to resolve the balance within 30 days, you will receive a notice that your account may be referred to an outside collection agency.
4. If you have not attempted to resolve your account with payment nor communicate with us regarding a payment plan, a final notification will be sent to your last known address informing you that your account is being referred to an outside collection agency. At the time your account is listed with the collection agency, your credit record may be adversely affected.

It is the experience of Family Medicine Health Center that the vast majority of our patients understand and cooperates with our long standing credit policy. Family Medicine Health Center is disclosing our policy to you now, so that we may avoid any misunderstanding in the future. By signing you acknowledge that you have read, understand and agree to comply with this credit policy.

_____ _____

Signature of Patient/Legal Guardian Date

Informed Consent for Telehealth Visit

I hereby consent to receiving treatment through telehealth from my Family Medicine Health Center provider or a qualified member of his or her care team. If patient is a minor, I consent to have the minor (identified below) receive treatment through telehealth. I understand that "telehealth" is the mode of delivering health care services through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. I understand that telehealth also involves the communication of my medical information, both orally and visually, to health care providers located at Family Medicine Health Center or elsewhere.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I understand that receiving treatment through telehealth does not mean I cannot receive in-person health care services, either today or in the future. I understand that there are limitations to the types of treatment that can be appropriately provided via telehealth, and that my provider determines whether or not it is appropriate for me to receive treatment via telehealth.

(2) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. I also understand that there are risks involved in receiving treatment via telehealth, such as interruption of the audio-video connection between me and my provider, or delays in receiving medical treatment because of technological failures.

(3) I understand that in some cases a patient may require an in-person visit following a telehealth visit to adequately assess or treat some health concerns, for procedures, immunizations, or other issues and I also understand that there will be an additional charge if an in-person visit is required.

(4) I understand that the patient must be located within the State of Idaho to participate in a telehealth visit.

I understand that I can discuss any questions that I have with my provider at the beginning of my telehealth visit, that my provider will answer any such questions, and that I may decline to continue the telehealth visit at any time.

By beginning my telehealth visit, I confirm that I have read and understand the information in this Informed Consent, and give my informed consent to receive treatment via telehealth.

Signature of Patient	Date
Print Patient Name	
Signature of Legal Guardian if Patient is a Minor	Date
Print Guardian Name	Relationship to Patient

Family Medicine Health Center- Meridian Schools Clinic

Consent Form

Student's Name _____ DOB: _____ Parent/Guardian Name: _____

AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN THE MERIDIAN SCHOOL CLINIC AND CHILD'S SCHOOL

I authorize Meridian School Clinic (MSC) to disclose certain protected health information about Minor to the school identified below ("School") under the following circumstances: i) the School is authorized to administer medications when School is in session; or ii) the School needs health information about the Minor to better support the Minor in the classroom. The information that is disclosed may include prescription information, treatment reports, lab tests, x-ray reports, accounting of visits, and other information directly related to the two stated purposes.

I consent to the release of my child's education records from West Ada District schools to MSC providers at the School-Based Health Center (SBHC) if necessary for treatment. I understand that the purpose of sharing these records with Meridian School Clinic- School-Based Health Center is to keep my child's SBHC providers informed of his/her academic program and progress in an effort to improve my child's success in school. This includes: Name of child, school, attendance, class schedule, disciplinary records and school health records.

This authorization automatically expires once the Minor no longer attends the School or if you revoke this authorization in a written document that is sent to the Health Center at the address above. Once health information is disclosed to the School, the information is no longer protected by the healthcare privacy regulations. Instead, the information becomes part of the Minor's education records and the School may not re-disclose the information without the prior written consent of the Minor's legal representative. Such consent must comply with FERPA (20 U.S.C. § 1232g; 34 CFR Part 99), a Federal law that protects the privacy of student education records. The Minor may still receive treatment at the Health Center even if you do not authorize the disclosure of information to the School.

My Child is currently enrolled in the following school:

Meridian Elementary 1035 NW 1st Street Meridian, ID 83642	Meridian Middle School 1507 W 8th Street Meridian, ID 83642	Meridian Academy 2311 E Lanark Meridian, ID 83642
Barbara Morgan STEM Academy 1825 W Chateau Dr Meridian, ID 83646	Crossroads Middle School 650 N Nola Road Meridian, ID 83642	Meridian High School 1900 W Pine Street Meridian, ID 83642
Chaparral Elementary School 1155 N Deer Creek Ln Meridian, ID 83642	Lewis and Clark Middle School 4141 E Pine Ave Meridian, ID 83642	**Other High School:**
Chief Joseph Elementary School 1100 E Chateau Drive Meridian, ID 83642	Lowell Scott Middle School 13600 W McMillan Rd Boise, ID 83713	
Frontier Elementary 11851 W Musket Drive Boise, ID 83713	Pathways Middle School 1855 E Heritage Park Lane Meridian, ID 83646	
Peregrine Elementary School 1860 W Waltman Street Meridian, ID 83642	**Other Middle School:**	
Ustick Elementary 12435 W Ustick Rd Boise, ID 83713		
Other Elementary School:		

AND

My Child's Primary Care Physician (if applicable)	Physician's Name: Clinic Name: Address: Office Phone Number Office Fax Number

By signing below I affirm that I have the authority to make health care decisions on behalf of the minor child identified above and understand and agree with the terms and conditions stated above. I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS, AND HAVE THESE QUESTIONS ANSWERED.

X _____ X _____

Parent, Personal Representative*, or adult student's signature Date

*if signed by a Personal Representative, please state the Personal Representative's authority to act for student.

Family Medicine Health Center Meridian Boys & Girls Club Transportation Agreement

BOYS & GIRLS CLUBS
OF ADA COUNTY

Dear parent/guardian,

The Boys & Girls Club of Ada County offers free transportation for your child from school to the Family Medicine Health Center Meridian Schools Clinic (FMHC-MSC). By signing this form below you are giving consent and authorization that Boys and Girls Club can provide transportation for your child when in need of medical assistance.

_____ _____

Child's name Date

PARENT OR GUARDIAN APPROVAL

I/we assume all risks and hazards incidental to such participation including transportation to and from Meridian Medicine Health Center; and hereby waive, release, absolve, indemnify and agree to hold harmless the Boys & Girls Club of Ada County, the organizers, sponsors supervisor, participants, and persons transporting my/our child, whether the result of negligence or for any other cause. I/we further give consent to him/her being given a physical exam or emergency treatment by a physician or hospital in case of an emergency.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**