# Annual Consent for Care

**Patient Name:_____ Patient Date of Birth:_____**

This consent form applies to Knox County Community Health Center (KCCHC) operating as a clinically integrated health care arrangement composed of KCCHC and practitioners collectively. All of the entities owned or operated by KCCHC and all practitioners associated with KCCHC will share medical information of patients as necessary to carry out treatment, payment and health care operations as permitted state and federal by law. The KCCHC offers medical, dental, mental health and behavioral health services that I may utilize as a patient of the KCCHC.

**CONSENT FOR MEDICAL CARE**: I understand that I have the right to make informed decisions about my health care treatment. I consent to have the health care professionals at KCCHC perform the appropriate services and treatments, which may include routine diagnostic procedures and such medical / dental treatment as the named attending practitioner or other member of the medical / dental staff consider to be necessary. I understand that the practice of medicine / dental / behavioral health is not an exact science and that diagnosis and treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as the result of any examination or treatment. I understand that it is customary that no substantial procedures are performed upon a patient unless and until have had had an opportunity to discuss them with the practitioner or other health professional and the patient has given their informed consent for that particular procedure. Each patient has the right to consent, or to refuse consent, to any proposed procedure or therapeutic course. I understand that my health care practitioner work as a team, and that in order to provide me with the best care, my attending practitioner and other health practitioners may consult with or make referrals to practitioner in other specialties, as appropriate, such as other Physicians, Dentists / Oral Surgeons, Pharmacists, Dieticians and/or Therapists, etc., including obtaining my medication history from various prescription databases. I know that I can ask any KCCHC health care professional that treats me questions about my treatment.

I understand that some medical practitioners on the staff of the KCCHC are not employees or agents of the KCCHC but are independent contractors who have been granted the privileges of using the facilities for the care and treatment of their patients.

KCCHC participates in one or more Health Information Exchanges. Your healthcare practitioners can use this electronic network to securely provide access to your health records for a better picture of your health needs. KCCHC, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment, or other healthcare operations in accordance with Federal regulations. This is a voluntary agreement. You may opt-out at any time by notifying the KCCHC office administrator.

**ASSIGNMENT OF INSURANCE BENEFITS**: I understand that charges are made for KCCHC services provided by the health center staff and its Affiliated Physicians / Dentists and Behavioral Health practitioners. These charges are covered by insurance or other third-party reimbursement of any type, I hereby authorize assignment of these benefits to KCCHC and its Affiliated Physicians / Dentists. I further authorize the KCCHC to release any information from my medical/dental records to medical assistance, Medicaid, Medicare, other governmental payers, private insurance companies or plans or organizations acting on their behalf, as may be necessary to determine benefits and process claims and others involved in the collection of accounts.

It is the policy of the KCCHC to provide essential medical, mental health, behavioral health and dental services regardless of the patient's ability to pay. I understand and agree that some services rendered are based on my ability to pay. If qualified, a discount may be applied to co-payment, co-insurance, and/or deductible balances that are greater than the nominal fee. To qualify for the "sliding fee scale", I must provide proof of household income and the household occupancy. If payment for other services is determined by and based on a sliding fee scale, I understand that I am responsible for my share of the cost of services rendered at the time of service and that failure to provide "proof of income" will result in me being charged 100% of the cost of services received and/or provided. I further understand that failure to comply with my responsibilities for payment of services rendered may result in suspension of appointments.

**ATTENTION PARENTS & GUARDIANS:** If you are signing on behalf of a minor (defined as a patient 18 years old or under in most treatment situations), please be aware that under certain circumstances, state and federal laws may determine that the minor controls the protected health information relating to certain aspects of the minors care or treatment. In this event, KCCHC may not release the applicable protected health information without the minor's written consent.

By signing below, I acknowledge that I have read and understood this form, or had this form read and explained to me. I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation will be effective except to the extent KCCHC has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

_____ _____

Signature of Patient/Parent/Guardian/Other Relationship (if not the patient)



Revised 08/16/2022; 09/12/2022; 06/2024
Created 01/01/2020