General Consent for Examination and Treatment

Medical / Dental / Behavioral / Rehabilitation / Routine Immunizations / HIV Testing

Patient Name: _____ **DOB**: ___/___/_____

1. I hereby authorize Metro Community Health Centers (Metro CHC) and/or its staff, including physicians, dentists, nurses and other staff to provide such medical and/or dental care and to administer such routine diagnostic tests and procedures, including, but not limited to: diagnostic x-rays; physical examination(s), administration and/or injection of pharmaceutical products, including routine immunizations and medications; drawing of blood specimens, use of local anesthesia and other non-invasive procedures as in the judgment of Metro CHC's personnel and/or my/the patient's physician(s) are deemed necessary or advisable in my/the patient's care. I acknowledge that this consent includes all future appointments and care rendered, and that further consent is not necessary unless I revoke this consent in writing.

2. I acknowledge that medicine is not an exact science and that diagnosis or treatment may involve risk of injury or even death, and no guarantees or assurances have been made to me concerning the results of treatments or examinations at Metro CHC.

3. Metro CHC may have the ability to access prescription medications I have filled or taken elsewhere, through connecting to medication history data as reported through pharmacy benefit managers or otherwise. Knowledge of other medications can help my doctor know whether there may be drug interactions or whether symptoms may be caused by a medication. Metro CHC has no responsibility as to accuracy of data obtained. I authorize Metro CHC to access this information.
4. I understand that Metro CHC supports education and training and may provide clinical opportunities for trainees in various disciplines. I understand that I have the right to refuse to have a trainee participate in my care.
5. I authorize Metro CHC to dispose of or use specimens taken for laboratory, pathology or other purposes.
6. I understand my (patient's) rights and responsibilities as a patient.

7. OCCUPATIONAL EXPOSURE: Regardless of whether I consent to elective HIV testing as set forth in Section 8 below, unless I cross out this provision, if a healthcare worker involved in my care and treatment becomes exposed to certain bodily fluids resulting in the possibility of transmission of a blood borne disease, my blood will be tested for HIV, Hepatitis B and Hepatitis C to determine risk of exposure.

8. HIV TESTING: Your Health Care Provider is required to make an offer of HIV testing as part of routine care to all persons between ages 13 and 64. You are strongly encouraged to accept testing since, as with other medical screenings, it may provide you with important information about your health and give you what you need to make good decisions for staying healthy. I have been given information regarding HIV, including seven points of information regarding HIV testing, how HIV can be transmitted, that there is treatment for HIV/AIDS, how to keep myself and others safe from HIV infection, that testing is voluntary and can be done anonymously, how my HIV-related information will be kept confidential and what laws protect people with HIV/AIDS from discrimination. I understand that the results of my HIV test will be documented on my medical chart. My consent may be given orally and documented by Metro CHC.

Please select one of the following:

- ☐ I do not want an HIV Test at this time.
- ☐ I wish to receive an HIV test.
- ☐ I wish to receive information as to an HIV test.

9. I understand that if I disagree with particular provision listed above, I have the right to cross out any provision and will initial next to my cross-out so that Metro CHC knows that I refused that provision.
I confirm that I have read/ or have had read to me the information above. I further confirm that I fully understand the above information and all my questions have been answered.

Patient/Guardian/Personal Representative: ☒_____

Signature Printed Name

_____ _____

Relationship, if signed by person other than patient Date

METRO Community Health Centers

Chronic Care Management - Patient's Participation Consent

Patient Name: _____ **DOB:** ___/___/_____

By signing this form, you consent to Metro Community Health Centers providing Chronic Care Management services (CCM services) to you, as described below.
CCM services are available to you, as a Medicare beneficiary, who have been diagnosed with 2 or more chronic conditions which are expected to persist for at least 12 months and which place you at significant risk or further functional decline. It is designed to help you manage your chronic conditions (such as diabetes, high blood pressure, depression) and improve your overall wellness.
Your CCM Care Team will provide you with non-face-to-face care coordination activities, including: 24/7 access to our CCM care team, including telephone access and other non-face-to-face means of communication (e.g., email, MCHC patient portal); systematic assessment of your health care needs; care management of your chronic conditions, including timely scheduling of all recommended preventive care services; medication review and oversight; creation and coordination of a comprehensive plan of care covering your health issues; management of care transitions between and among home and community based providers and settings, including referrals to other health care providers, follow-up after visits to the emergency department and/or discharge from hospital or other health care facility.

When providing CCM services, your CCM care team will:
Explain to you (and your caregiver, if applicable), and offer to you, all the CCM services that are applicable to your conditions. Explain to you the applicable cost sharing. Provide to you a copy of your Care Plan. Stop CCM services, if you revoke this consent form.

Patient's Acknowledgement and Authorization: By signing this consent form, I agree to the following:
I authorize electronic communication of my medical information with other providers involved in my care as part of coordination of my care.
I acknowledge that Medicare will allow Provider to bill for CCM services during any month that I was provided with at least 20 minutes of non-face-to-face care coordination activities.
I acknowledge that only one physician can furnish and bill for CCM services provided to me during a calendar month. I will notify my CCM care team if I enter into a similar agreement with another provider/practice.
I understand that I can decline, transfer, or terminate CCM services at any time by revoking this consent effective at the end of the then-current month. I will notify my CCM care team if/when I decide to revoke this consent.

☐ **1. I GIVE CONSENT to participate in Chronic Care Management services program**
☐ **2. I DENY CONSENT to participate in Chronic Care Management services program**

_____ _____
Signature of Patient/Parent/Legal Guardian/Personal Representative **Date**

_____ _____
If not the patient, Print Name of person signing this authorization **Relationship to patient/Authority to sign on patient's behalf**