CHRISTIAN COMMUNITY HEALTH CENTER

CONSENT FOR TREATMENT/SERVICES

Patient/Client Name_____ **Date of Birth**_____

I, the undersigned, hereby consent to participate and receive services for myself, or my child, provided by Christian Community Health Center (CCHC) that is deemed necessary. I understand that these services may include, but are not limited to: Initial and ongoing assessment, individual service/care planning, referrals, treatment and supportive services.

I hereby request and consent to the following services: ***(please check all services you are requesting)***

- ☐ Housing
- ☐ Employment
- ☐ Case management
- ☐ Mental Health
- ☐ Substance abuse
- ☐ Health Education
- ☐ Support groups
- ☐ Transportation assistance
- ☐ Domestic violence services
- ☐ HIV/AIDS (inclusive of testing)
- ☐ Footprint services
- ☐ Medical - examinations, tests (including STI testing), procedures/treatment
- ☐ Dental - examinations, procedures/treatments
- ☐ Other (please specify): _____

I also consent to the administration of childhood and/or adult vaccinations as designated and applicable.

I have been informed of the nature and availability of the above services and have been given the opportunity to ask questions. I understand my consent is voluntary and that I may revoke my consent in writing at any time.

I acknowledge that no guarantees have been given to me by anyone at CCHC regarding the results of tests, examinations, treatments, immunizations, procedures or any other services to be provided. I also understand that my access to and continuation of identified services with CCHC may depend on any of the following: eligibility criteria, funding availability, insurance/income status and/or other program or funding source guidelines.

Right to Refuse Treatment: In giving my consent to treatment, I understand that I retain the right to refuse any particular examination, test (including HIV and/or STI testing), procedure, treatment, therapy or medication recommended or deemed medically necessary by my provider or care team. In doing so, I may be asked to sign a release to refuse treatment. If an HIV or STI test has been refused, it will not be performed.

Opt-Out: ☐ I do not wish to receive the following test(s)/procedure(s) _____

I also understand and consent to the following regarding my and/or my child's information:

- It may be entered into the CCHC practice management, electronic health/dental record or other electronic computer system that the program(s) use;
- I grant permission for 3rd party/external auditors to view my personal health information for purposes of program evaluation; as well as CCHC for health care operations, quality assurance and billing purposes; and
- I am responsible for any costs/fees incurred at the time of service required by the program(s); and not covered by my insurance carrier or other approved/designated payor; and,
- I indemnify and hold harmless CCHC and all of their officers, agents, employees, attorneys, directors, insurers, affiliates, health networks and assigns from any and all liability for acting in reliance on this consent.

By signing below, I acknowledge that I have read this consent form, or have had the consent form read to me; and I understand and agree/consent to all of the provisions contained herein.

_____ _____ _____

Signature of Client/Legal Representative | Date | Relationship to Client (if applicable)

_____ _____

Signature of Witness | Date

- **Consent will expire one year from the above date**