



PARENT/GUARDIAN Name: _____ Relationship to Patient: _____

PATIENT (Student) Name: _____ DOB: _____

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I have received a copy of OneWorld Community Health Centers' Notice of Privacy Practices

Consent for Use and Disclosure of Health Information

Purpose: This form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Privacy Officer Telephone: 402-502-8881 E-mail: jmayhew@oneworldomaha.org Address: 4920 South 30th Street, Omaha, NE 68107

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and health care operations.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Authorization to Treat and Assignment of Benefits

Authorization for Medical Treatment: I authorize the physician(s), therapist(s), their assistants and/or designees in charge of my medical care to administer any treatments that may be necessary or advisable in my diagnosis and treatment at the OneWorld Community Health Centers or any of their facility(s). I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or therapist(s) whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at this facility(s). I acknowledge that my care is under the direction of my treating physician(s) and the facility(s) will follow the instructions of my physician(s) in the provision of said care. I understand in the case of HIV testing ordered by my physician(s), therapist(s), their assistants and/or designees there are two options for testing and that (1) if tested my HIV test result will be confidential, but no anonymous, and (2) an anonymous test is available from other organizations. I confirm that as applicable, printed materials regarding HIV, have been provided to me. I know I have the right to refuse testing.

Assignment of Facility Benefits: I hereby assign all insurance benefits and/or Medicare/Medicaid benefits to Facility(s) and authorize direct payment to Facility(s). This assignment specifically includes, but is not limited to major medical and disability insurance proceeds and benefits. This assignment also includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgment for personal injuries caused by a third party. I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be valid as the original.

Authorized Representative: I hereby authorize Facility(s), its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by Facility(s).

Statement of Responsibility: I understand that I am financially responsible to the Facility(s) as the patient, parent, guardian, and conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, or out-of-pocket expenses.

Signature for Notice of Privacy Practices, Consent for Use and Disclosure of Health Information, and for Authorization to Treat and Assignment of Benefits.

The undersigned acknowledges the receipt of OneWorld Community Health Centers' Notice of Privacy Practices, will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations, and **authorization for medical treatment.**

Name: _____ Signature: _____ Date: _____

TELEHEALTH PATIENT CONSENT FORM

I, the undersigned as the patient or parent/legal guardian for the minor patient, agree to me and/or my child receiving a behavioral health telehealth consultation service. I understand that the licensed mental health care practitioner or intern supervised by a licensed mental health practitioner is located at OneWorld Community Health Centers, Inc. at any of its locations in Nebraska. A telehealth service means that my visit or my child's visit with a licensed mental health care practitioner at another location (the distant site) will happen by using special audiovisual equipment. The telehealth service will not be the same as a face-to-face visit since my child and/or I will not be in the same room as the licensed health care practitioner. I understand that the telehealth service will not be recorded and if the clinical supervisor requests to observe or participate in the session, I will be informed and given the opportunity to accept or decline this request.

I, as the patient and/or as the parent/legal guardian for the minor patient, also understand and agree that:

I can decline the telehealth service at any time without affecting my right and/or my child's right to future care or treatment, any program benefits to which my child would otherwise be entitled cannot be taken away.

I may have to travel for me and/or my child to see a licensed health care practitioner in-person if I decline the telehealth service.

If I decline the telehealth services, the other options and alternatives available to me and/or my child, including in-person services, are as follows: seek alternative providers in the community or to be seen at One World Community Health Centers, Inc. at any of its locations in Nebraska.

The same confidentiality protections that apply to my or my child's other medical care also apply to the telehealth service. The legal exceptions to confidentiality occur if I and/or my child report abuse or harm to self and/or others.

I will have access to all medical information resulting from the telehealth service as provided by law.

The information from the telehealth service (images that can be identified as mine and/or my child's or other medical information from the telehealth service) cannot be released to researchers or anyone else without my additional written consent.

I will be informed of any individuals who will be present at the originating site and the distant site during my and/or my child's telehealth service.

I may exclude anyone from any site during my and/or my child's telehealth service.

I and/or my child may see an appropriately trained staff person or employee in-person immediately after the telehealth service if an urgent need arises or I will be told ahead of time that this is not available.

I have read this document carefully, and my questions have been answered to my satisfaction.

Parent/Legal Guardian Signature: _____ Date: _____

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