

Patient Informed Consent

- **Consent to Treatment:** [OBJ]

I authorize and give my voluntary consent to Duffy Health Center to assess, prescribe, and administer treatment including patient education, therapy, and minor surgery for diagnoses and treatment as deemed necessary or advisable for my overall well-being. I understand that my treatment will include a discussion of: A diagnosis, if known; the nature and purpose of a proposed treatment or procedure; the risks and benefits of a proposed treatment or procedure; alternatives; the risks and benefits of the alternative treatment or procedure; and the risks and benefits of not receiving or undergoing a treatment or procedure. I understand that I may terminate treatment at any time and that Duffy Health Center retains that same right. By signing this form, I am consenting to Medical, Behavioral Health and/or Case Management/outreach services as indicated at Duffy Health Center as well as at other sites where Duffy Health Center provides care.

- **Consent for Telehealth Treatment:**

I acknowledge that I have the option to have appointments via telehealth and that I have the right to refuse telehealth services at any time. I understand that telehealth involves receiving healthcare services through video, phone, or other electronic methods. I understand that I must be physically located within the state of Massachusetts at the time of the telehealth appointment, and that staff will verify my physical location at the beginning of each appointment. Additionally, I understand that I may not be hospitalized or receiving in-patient services during a telehealth appointment. While telehealth offers convenient access to care, it may involve risks, such as technical difficulties or limitations in performing physical exams. If an in-person visit is necessary, I will be informed. In the event of an emergency or urgent medical issue, telehealth may not be appropriate, and I understand that I should seek in-person care or call emergency services. By signing below, should I choose to utilize telehealth services, I consent to receive these services as part of my plan of care.

- **Assignment of Benefits:**

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled and any and all claims against third-party insurers, or governmental agencies for services provided to me at Duffy Health Center. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to Duffy Health Center. I assign Duffy Health Center any and all claims against third party insurers, or governmental agencies for services provided to me. I understand that I am responsible for any health insurance deductible and co-insurance. I request that direct payment be made to Duffy Health Center in the settlement of such claims.

- **Medicare Authorization (Pertains to Medicare Beneficiaries Only):**

I request payment of authorized Medicare Benefits on my behalf for any services to me by or in Duffy Health Center, including physician services, directly to Duffy Health Center. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.



DATE: _____

- **Authorization to Release Health Information:**

I realize that my treatment is confidential, and information may not be released without my written consent, except as legally authorized. I understand that my treatment record is the property of Duffy Health Center. I authorize Duffy Health Center, its agents, servants and employees to release information necessary to my treatment which may include medical, mental health, alcohol and or substance abuse, HIV/AIDS and any related condition for the purpose of payment of bills and treatment by primary care practitioners, referring practitioners, and consulting practitioners. I understand that I am authorizing Duffy Health Center to: Release any information necessary to insurance carriers regarding my illness and treatments; process insurance claims generated in the course of examination or treatment; and allow a photocopy of my signature to be used to process insurance claims. I understand that I am consenting to allow my provider to use the Massachusetts Health Information Highway (MassHIway), Care Everywhere, and Epic to disclose my medical information to other authorized health care organizations for purposes of care coordination or patient treatment. I understand that no guarantee can be made to me as to the results of treatment or examination.

- **Notice of Patient's Rights and Responsibilities, Patient Grievance Procedure, Notice of Privacy Practices and Notice of Availability of Financial Assistance**

I acknowledge that I have been given copies of the documents entitled Notice of Patient's Rights and Responsibilities, Patient Grievance Procedure, Notice of Privacy Practices and Notice of Availability of Financial Assistance and that I have read and understand my rights.

These authorizations will remain in effect until revoked by me in writing

I have read and certify that I fully understand the information provided on this form and Duffy Health Center staff has adequately answered any questions I may have about the above material.

Patient Name (printed): _____ **DOB:** _____

Guardian Name (if applicable -printed): _____

Patient Signature: _____

Guardian Signature (if applicable): _____