

Carolina Family Health Centers, Inc.

*Carolina Family Dental Center • Freedom Hill Community Health Center • Harvest Family Health Center
• Wilson Community Health Center*

GENERAL CONSENT FOR TREATMENT

I understand that Carolina Family Health Centers, Inc. (CFHC, Inc.) is an integrated healthcare program made up of various entities, including (but not necessarily limited to) Carolina Family Dental Center, Freedom Hill Community Health Center, Harvest Family Health Center, and Wilson Community Health Center.

The following are the conditions for services provided by CFHC, Inc. The general consent for treatment provides CFHC, Inc. with your permission to perform reasonable and necessary medical/dental examinations, testing, and treatment. These conditions and consent will remain fully effective until it is revoked by you in writing. You have the right at any time to discontinue services.

General Consent for Treatment - By signing below, I am indicating that (1) this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other satellite office under common ownership. I understand that I have the right to discuss the treatment plan with my provider about the purpose, potential risks, and benefits of any test ordered for me. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made as to the result of treatments or examinations. I understand if I have any concerns regarding any test or treatment recommended by my healthcare provider, I am encouraged to ask questions.

My signature below indicates that I voluntarily request a physician, dentist, advanced practitioner (Nurse Practitioner, Physician Assistant, or Clinical Pharmacist Practitioner), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical/dental examination, immunizations, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms before the test(s) or procedure(s) are performed.

Authorization for Release of Information - I acknowledge that under the Health Insurance Portability and Accountability Act (HIPAA) and the Coronavirus Aid, Relief and Economic Security (CARES) Act, CFHC, Inc. is authorized to release my medical records; including records regarding the treatment of Substance Use Disorders to other healthcare specialists, entities, or regulatory agencies to carry out treatment, obtain payment, conduct certain healthcare operations, and comply with federal and state laws. Under the 21st Century Care Act, CFHC, Inc. cannot block my protected health information from being electronically shared with other health information exchange platforms or applications unless I request this information be restricted or my provider determines the transmission of this information could be harmful to me.

The Reproductive Health Care Privacy Rule prohibits the use and disclosure of protected health information by CFHC, Inc. and its staff to conduct criminal, civil or administrative investigations into or impose criminal, civil or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, where such health care is lawful under the circumstances in which it is provided or the identification of any person for the purpose of conducting such investigation or imposing such liability. This applies when the reproductive healthcare is lawful under the law of the state in which such health care is provided under the circumstance in which it is

provided or the reproductive health care is protected, required, or authorized by law. CFHC, Inc. staff presumes reproductive healthcare provided by another person or entity is lawful unless an exception applies as outlined in the law.

I give permission to CFHC, Inc. and their employees, agents, and contractors to take photographs or make videos or drawings of me for permissible treatment, payment, or healthcare operations purposes (which may include quality assessment, education, and training), as long as consistent with policies and laws that protect my rights.

Acknowledgment of Receipt of Notice of Privacy Practices - I acknowledge that I have received a copy or been given the opportunity to review Carolina Family Health Centers, Inc.'s *Notice of Privacy Practices*. I understand that, as provided in the Notice, the terms of the Notice may change. I may obtain a revised copy by contacting the Privacy Officer.

Acknowledgment of Receipt of Notice of Nondiscrimination and Notice of Availability– I acknowledge that I have received a copy or been given the opportunity to review Carolina Family Health Centers, Inc.'s Notice of Nondiscrimination and Notice of Availability.

Financial Responsibility – I agree to be responsible for my co-payments, deductibles, or other charges for services not covered or paid by insurance or other third-party payers. I authorize CFHC, Inc. to file any claims to my insurance, if applicable, for payment of any portion of my bill and assign all rights and benefits to CFHC, Inc. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses, and interest in the event CFHC, Inc. takes action to collect the same because of my failure to pay in full all incurred charges. If I have overpaid any of my accounts with CFHC, Inc., I agree that the overpayment may be applied to pay any outstanding charges on any of my other accounts with CFHC, Inc.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request - I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. I certify that the information given by me or by my authorized representative in applying for payment for my healthcare under the Medicare or Medicaid programs is correct. I request that payment of authorized benefits be made to CFHC, Inc. on my behalf. I authorize CFHC, Inc. to bill directly and assign the right to all health and liability insurance benefits otherwise payable to me, and I authorize direct payment to CFHC, Inc.

Authorization to Contact – CFHC, Inc., or their agents or representatives, may contact me by telephone at any number contained in my CFHC, Inc. records, including wireless telephone numbers, for the purpose of servicing my account and collecting amounts due. Methods of contact may include prerecorded or artificial voice messages and the use of automatic dialing services.

Social Security Number - I have given my social security number voluntarily. CFHC, Inc. may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

Personal Property - I understand that CFHC, Inc. does not assume responsibility for my personal belongings that I keep in my possession, and I release CFHC, Inc. from all liability for the loss or theft

of, or damage to, such belongings.

I UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT IN WRITING. MY WITHDRAWAL WILL NOT BE EFFECTIVE FOR ACTIONS ALREADY TAKEN BY CFHC, INC., OR IN PROGRESS.

I AUTHORIZE CFHC, INC. TO RELEASE ALL RECORDS REQUIRED TO ACT ON THESE REQUESTS. I HAVE READ AND UNDERSTAND THIS FORM, RECEIVED A COPY, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS FORM.

Patient's Name (printed)

DOB

MR#

Patient/Parent/Legal Guardian's Signature
(Parent must sign for minor child)

Date

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Notice of Availability	
ENGLISH	If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 252-293-0013 or speak to your provider.
Español (Spanish)	Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 252-293-0013 o hable con su proveedor.
中文 (Chinese)	如果您說[中文]，我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 252-293-0013 或與您的提供者討論
Việt (Vietnamese)	Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 252-293-0013 hoặc trao đổi với người cung cấp dịch vụ của bạn.
한국어 (Korean)	[한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 252-293-0013 번으로 전화하거나 서비스 제공업체에 문의하십시오.
Français (French)	Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 252-293-0013 ou parlez à votre fournisseur.
العربية (Arabic)	إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 0013-293-252 أو تحدث إلى مزود الخدمة الخاص بك.
Hmoob (Hmong)	Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntauv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 252-293-0013 los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.
Русский (Russian)	Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 252-293-0013 или обратитесь к своему поставщику услуг.
Tagalog	Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 252-293-0013 o makipag-usap sa iyong provider.
తెలుగు (Telugu)	మీరు తెలుగు మాట్లాడితే, మీకు ఉచిత భాషా సహాయ సేవలు అందుబాటులో ఉంటాయి. యాక్సెస్ చేయగల ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక సహాయాలు మరియు సేవలు కూడా ఉచితంగా అందుబాటులో ఉంటాయి. 252-293-0013 కి కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.
Portuguese (Brazil)	Se você fala Português do Brasil, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 252-293-0013 ou fale com seu provedor.
Deutsch (German)	Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 252-293-0013 an oder sprechen Sie mit Ihrem Provider.
हिंदी (Hindi)	यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 252-293-0013 पर कॉल करें या अपने प्रदाता से बात करें।
தமிழ் (Tamil)	நீங்கள் தமிழ் பேசினால், இலவச மொழி உதவி சேவைகள் உங்களுக்கு கிடைக்கும். அணுகக்கூடிய வடிவங்களில் தகவல்களை வழங்குவதற்கான பொருத்தமான துணை உதவிகள் மற்றும் சேவைகளும் இலவசமாகக் கிடைக்கின்றன. 252-293-0013 ஐ அழைக்கவும் அல்லது உங்கள் வழங்குநரிடம் பேசவும்.