Sawtooth Mountain Clinic
Together Through Life
a 501©(3) not-for-profit organization

GENERAL CONSENT AND AUTHORIZATION

Sawtooth Mountain Clinic (SMC) is dedicated to providing primary care, dental and behavioral health services to all patients. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. SMC patients may be referred to providers from other health care specialties within the SMC treatment team.

Patients are seen by appointment only, except in emergencies. Patients must call in advance if they cannot keep their appointment.

Information about a patient will not be given to anyone outside SMC, including family and friends, unless the patient (parent or legal guardian, if a minor) gives written permission. However, we may release patient information to others without the patient's permission if 1) the patient poses a threat to him/herself or others; 2) the patient is unable to protect him/herself from risk of harm; 3) the patient is in the legal custody of a government agency or facility; 4) there is evidence of child abuse; 5) the patient's clinical records are requested under court order; or 6) the patient is referred to a collection agency in order to collect on an overdue account.

In order for SMC to treat you, we ask you to sign below indicating your consent to treatment:

A. I give my consent to SMC providers, healthcare workers, and behavioral health staff to perform exams, treatments, assessments, x-rays, lab tests and operations, and to give me medicine that they believe is necessary or helpful to my health.
B. I understand that while I am receiving care, a healthcare worker may accidentally be exposed to my blood or other body fluid. If this rare event occurs, I consent to have my blood tested for blood-borne pathogens, such as Hepatitis B and C, and HIV. I understand that the test results will become a part of my medical record and will be released to the exposed healthcare worker and a positive result must be reported to the state by law.
C. I authorize payment from Medicare, Medicaid, insurance and any other funds be paid directly to SMC from my care and treatment. I understand that it is my responsibility to comply with the requirements of my insurance policies.
D. I agree to pay any charges not covered by insurance, government programs (including Medical Assistance), or other funds, such as SMC's Sliding Fee Scale program. I further agree to pay reasonable attorney fees and all costs of collection in the event my account is turned over to an attorney or collection agency. I understand that it is my responsibility, not SMC's, to negotiate for payment of a claim that is disputed by the payer.
E. A copy of the Patient's Bill of Rights and SMC's Credit Policy has been given to me.
F. I request that payment of authorized Medicare benefits be made on my behalf to SMC for any services furnished me by an SMC provider. I authorize any holder of medical or other information about me to be released to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

GENERAL CONSENT AND AUTHORIZATION (Continued)

SMC respects your right to privacy. Under the following conditions your health information will only be released with your consent:

G. I authorize SMC to release my medical records to, and as needed, to discuss my care with my doctors, other healthcare providers, and anyone else SMC either believes to be involved in, or who may participate in my care, treatment, and case management, and to release that information to my insurance provider. This includes information related to the diagnosis and treatment of mental illness, alcohol or drug use, sexually transmitted diseases (STDs), HIV test results, developmental disabilities and genetic testing results.

H. I authorize SMC to release my protected health information to parties who are responsible for or who facilitate payment of my bill, fraud investigation, care management, or quality improvement. This includes behavioral health and chemical dependency information. SMC may also release my protected health information to suppliers of medical equipment, special transportation, or other health services so they can request payment from my insurance or other payer. I also authorize SMC to release my protected health information to e-Prescribing networks to facilitate prescription management.

I. I agree to the presence of students during tests, exams, medical treatments and other services at SMC. I understand that SMC will also seek my oral permission to have non-SMC persons present during any services.

J. I understand that this authorization ends one (1) year from the date signed except for purposes of payment and research.

K. I acknowledge that a copy of the current Notice of Privacy Practices (HIPPA) has been provided to me and is available to me via postings in the registration areas and on the website www.sawtoothmountainclinic.org. I understand that I can ask for a copy of the notice at any time.

- I understand that I may revoke this permission at any time by notifying SMC in writing. No further release will take place after the date notified.
- I understand that other parties may use or disclose health information received from SMC.
- I understand that SMC will treat me whether or not I consent to section H of this document.
- I understand I will receive a copy of this form if I so choose.

If I am signing as Authorized Representative of the patient, I am:

[ ] Court Appointed Guardian/Custodian [ ] Other _____

_____ _____

Signature (Patient or Authorized Representative) Date

_____ _____

Print Patient Name Patient D.O.B

_____

Witness (Signature by mark must be witnessed)