Bois Forte Health and Human Services
Consent for Services

In order for Bois Forte Health & Human Services to treat you, we ask you to sign indicating your consent to treatment. Bois Forte Health & Human Services respects your right to privacy. Under the following conditions your health information will only be released with your consent:

Medical

A. I give my consent to Bois Forte Health & Human Services doctors and healthcare workers to perform exams, treatments, x-rays, and lab tests, 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 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.

D. I consent for medical photographs to be made of me (or the person for whom I am legal guardian). I understand that the information may be used in my medical record, and/or for purposes of medical teaching. Refusal to consent to photographs will in no way affect the medical care I will receive.

E. I authorize Bois Forte Health & Human Services to release my medical records to, and as needed, to discuss my care with my doctors, other healthcare providers, and anyone else Bois Forte Health & Human Services either believes to be involved in, or who may participate in my care, treatment, case management and/or discharge planning. This includes source documents (such as x-rays). I authorize Bois Forte Health & Human Services to electronically release my protected health information to other healthcare providers involved in my care and treatment and who share electronic medical record systems with Bois Forte Health & Human Services. 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.

F. To improve the coordination of my care, I authorize Bois Forte Health & Human Services to electronically release my protected health information to other healthcare providers involved in my care and treatment and who participate in local, state and/or national Health Information Exchanges. This may include 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.

G. I authorize Bois Forte Health & Human Services to release my protected health information to insurance companies, government programs, and other 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. Bois Forte Health & Human Services 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 Bois Forte Health & Human Services to release to e-Prescribing networks to facilitate prescription management.

H. When consent is required under applicable state law, I authorize Bois Forte Health & Human Services to access my current prescription history of regulated controlled substances in any applicable state databases.

I. I authorize Bois Forte Health & Human Services to release information from my medical records: as needed by the Federal Food and Drug Administration (FDA) or manufacturers of drugs or medical devices to contact me about defects or recalls; or to emergency service providers involved in my care before and during transport to Bois Forte Health & Human Services, for quality improvement.

J. I agree to the presence of students, observers from other healthcare facilities, healthcare consultants and approved representatives of medical service providers during tests, exams, medical treatments and other services at Bois Forte Health & Human Services. I understand that Bois Forte Health & Human Services will also seek my oral permission to have non-Bois Forte Health & Human Services persons present during any services.

Billing

K. I authorize payment from Medicare, Medicaid, insurance and any other funds be paid directly to Bois Forte Health & Human Services for my care and treatment. I understand that it is my responsibility to comply with the requirements of my insurance policies.

L. I agree to pay any charges not covered by insurance, government programs (to include Direct Care and Purchased Referred Care), or other funds. 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 Bois Forte Health & Human Services', to negotiate for payment of a claim that is disputed by the payer.

M. I request that payment of authorized Medicare benefits be made on my behalf to Bois Forte Health & Human Services for any services furnished me by a Bois Forte Health & Human Services provider and/or in a Bois Forte Health & Human Services facility. I authorize any holder of medical or other information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

N. I authorize my health insurance plan to release to Bois Forte Health & Human Services my protected health information about services I have received from Bois Forte Health & Human Services and other care providers unrelated to Bois Forte Health & Human Services. Bois Forte Health & Human Services may use this information for treatment, payment, operations and case management purposes.

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

P. If this is my first visit to this Bois Forte Health & Human Services, I acknowledge that a copy of the current Notice of Privacy Practices has been provided to me. 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 Bois Forte Health & Human Services 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 Bois Forte Health & Human Services.
- I understand I will receive a copy of this form.

_____ _____

Patient / Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print Name Relationship to patient