Philadelphia FIGHT Community Health Centers

ADOLESCENT CONSENT FOR TREATMENT AND RELEASE OF HEALTH INFORMATION

Rev.01/01/2020, BOD Approved 01/22/2020

NAME OF PATIENT: _____ Patient's Date of Birth:_____ Date: _____

FOR LEGALLY AUTHORIZED REPRESENTATIVES WHO ARE COMPLETING THIS CONSENT ON BEHALF OF A PATIENT:
Name of Legally Authorized Representative: _____
Legally Authorized Representative's Relationship to Patient:_____
(e.g. Parent, Legal Guardian)

1. **CONSENT FOR TREATMENT:** I, as the patient or patient's legally authorized representative, hereby consent to the performance of such diagnostic procedures and/or medical treatment, including the administration of blood products, as deemed necessary or advisable by the physician/s and/or health care provider/s at the Jonathan Lax Treatment Center, John Bell Health Center, Y-HEP Health Center, Pediatric and Adolescent Health Center, Clinica Bienestar, Broad Street Ministry Health Center and /or Philadelphia FIGHT Dental Services (all entities referred to collectively as the Philadelphia FIGHT Community Health Centers). I hereby consent to the performance of all nursing and technical procedures and tests as directed by these physician/s and/or health care provider/s.

2. **COMPLIANCE WITH RULES AND REGULATIONS:** In consideration of treatment, I agree to abide by the rules of the Philadelphia FIGHT Community Health Centers.

3. **ASSIGNMENT OF BENEFITS:** As the patient or patient's legally authorized representative, I hereby make the assignment of benefits as set forth below:

   MEDICARE AND/OR MEDICAID: I authorize any holder of medical, dental or other protected health information about me, the patient, or about the patient that I am legally authorized to represent, to release this information to Medicare and/or Medicaid. This information is disclosed for the purpose of billing and obtaining payment for care and for obtaining authorization for necessary treatment. I hereby authorize direct payment to Philadelphia FIGHT for medical, dental and/or surgical benefits from Medicare and/or Medicaid. I also permit a copy of this authorization to be used in place of the original.

   GENERAL AUTHORIZATION: I authorize any holder of medical, dental or other protected health information about me, the patient, or about the patient that I am legally authorized to represent, to release this information to any another medical practice or medical provider involved in my, or the patient's care. This information is disclosed for the purpose of billing and obtaining payment for care, for obtaining authorization for necessary treatment and for coordination of care.

   I authorize any holder of medical and/or dental information or other protected health information about me, the patient, or about the patient that I am legally authorized represent, to release this information to my or the patient's insurance company, the intermediaries or carriers, and/or to my or the patient's attorney. This information is disclosed for the purpose of billing and obtaining payment for care. I hereby authorize direct payment to Philadelphia FIGHT for medical, dental and/or surgical benefits from my or the patient's private insurance company or other health plans. I also permit a copy of this authorization to be used in place of the original.

4. **IMMUNIZATION INFORMATION SYSTEM:** I authorize the physician/s and/or health care provider/s and/or public health agency to collect and enter my immunization records, or the immunization records of the patient I am legally authorized to represent, into the Department of Health and Human Services' Immunization Information System (IIS). The IIS is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as all my or the patient's health care providers to assist in medical care and treatment. In addition, information may be released to other facilities at which I, or the patient, am enrolled as a patient to comply with state immunization requirements.

5. **PHARMACY BENEFITS STATEMENT:** A "Pharmacy Benefits Statement" (PBM) is a statement that shows all medications that have been processed through an insurance company for any period of time regardless of the prescriber. I authorize Philadelphia FIGHT to view my PBM, or the PBM of the patient I am legally authorized to represent, download my or the patient's PBM, and make it an ongoing part of my or the patient's electronic medical records.

6. **CLINICAL TRIALS ELIGIBILITY SCREENING:** Philadelphia FIGHT conducts clinical trials of new and potential treatments for different disease states. Additionally, FIGHT studies various factors related to these disease states such as prevention of diseases and treatment adherence. The purpose of this research is the overall goal of improving health outcomes. I authorize Philadelphia FIGHT health care provider/s and/or Philadelphia FIGHT research staff to review my medical/dental chart, or the medical/dental chart of the patient I am legally authorized to represent, and contact me if a clinical trial is appropriate for or the patient. This is not authorization to enroll myself or the patient in any trial and I understand that I or the patient is not obligated to participate in any research.

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7. **FINANCIAL ASSISTANCE/SLIDING FEE PROGRAM:** I understand that if I, as the patient, am uninsured or underinsured, or the patient I legally represent is uninsured or underinsured, financial assistance may be available. If I need assistance I can contact the Health Centers' benefits coordinators or medical case managers for further information about financial assistance for uninsured or underinsured patients. I understand that I will need to provide timely information to verify my or the patient's eligibility for sliding fee/financial assistance. I understand that my or the patient's application for financial assistance/sliding fee expires one year from the date of the original application and to continue receiving financial support I must reapply if the application has expired.

8. **HEALTH INFORMATION EXCHANGE:** I understand that Philadelphia FIGHT participates in certain health information exchanges with other hospitals and health centers, including the "HealthShare Exchange of Southeastern Pennsylvania, Inc., ("HSX"). I have been informed that my health information, including limited information relating to mental health and substance abuse services that I may receive at Philadelphia FIGHT, will be shared with these exchanges. Notes from my psychiatrist, mental health therapist or addiction counselor will not be shared, but diagnosis codes and a history of my visits will be shared. I understand that information about me is being shared with providers and public health officials outside of the health center for treatment purposes, in order to better coordinate my care and to assist providers and public health officials in making more informed decisions. I have been advised by Philadelphia FIGHT that I have the right to "opt-out" of health information exchanges at any time. I understand that I can request a copy of the "opt-out" form from Philadelphia FIGHT and direct Philadelphia FIGHT to disable access to my health information, except to the extent that disclosure of such information is permitted or mandated by law.

9. **REQUIREMENTS OF OUR FUNDERS:** I understand and agree that Philadelphia FIGHT may use and disclose medical/dental information about me, the patient, or about the patient that I am legally authorized to represent, to comply with the requirements of Federal, state, and local government funders.

10. **NOTICE OF PRIVACY PRACTICES, PATIENT BILL OF RIGHTS AND RESPONSIBILITIES, AND GRIEVANCE PROCEDURES: (INITIAL)**

_____ INITIALS **Acknowledgment:** I acknowledge that I have been given and received a copy of the Philadelphia FIGHT Notice of Privacy Practices, Patient Bill of Rights and Responsibilities, and Grievance Procedures. I understand that Philadelphia FIGHT reserves the right to change the terms of the Notice of Privacy Practices from time to time and that I may contact Philadelphia FIGHT at any time to obtain the most current copy of the Notice of Privacy Practices.

If I have a concern about Philadelphia FIGHT Notice of Privacy Practices, Patient Bill of Rights and Responsibilities, or Grievance Procedures, I may contact Mimi McNichol, by phone: (215) 985-4448 ext. 223, by email: mcnichol@fight.org, or by mail: 1233 Locust Street, 5th floor, Philadelphia, PA, 19107.

If YOU are between the age of 14 to 18 years old AND consenting for yourself- CHECK ALL BOXES BELOW THAT APPLY TO YOU

- ☐ I am seeking treatment for sexual and reproductive health services (except abortion)
- ☐ I am seeking treatment, and disclosure of treatment to my guardian/s would subject me to abuse or neglect
- ☐ I am married or I was previously married
- ☐ I am pregnant or I was previously pregnant (regardless of whether or not the pregnancy resulted in the birth of a child)
- ☐ I am emancipated (meaning legally emancipation OR have left your parent/guardians household by agreement or demand)

IF NONE of the above applies to you, you need to have your parent or legal guardian consent on your behalf. Please go to the Frontdesk for assistance.

BY MY SIGNATURE, I CERTIFY THAT I AM THE PATIENT OR LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ PARAGRAPHS 1-9 OF THIS DOCUMENT, UNDERSTAND ITS CONTENT, AND AGREE TO ITS TERMS. I UNDERSTAND THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

PRINTED NAME of Patient or Legally Authorized Person:_____

Signature of Patient or Legally Authorized Person_____ Date:_____

TO PHILADELPHIA FIGHT STAFF: ALL HIV-RELATED INFORMATION FOUND IN PATIENT RECORDS IS PROTECTED BY PENNSYLVANIA'S CONFIDENTIALITY OF HIV-RELATED INFORMATION ACT, KNOWN AS ACT 148. YOU ARE PROHIBITED FROM DISCLOSING THIS INFORMATION WITHOUT THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, UNLESS OTHERWISE PERMITTED BY LAW. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.