Consent for Health Care Services

Patient's Full Name (PRINT) _____ **Patient's Date of Birth** _____

I hereby authorize International Community Health Services (ICHS) and its Providers to provide health care services, including evaluation, examination, and therapeutic procedures, for me as deemed necessary or advisable by my Provider to assess and treat my health condition. I understand that I have the right to be actively involved in decisions regarding my care and may ask questions about the nature and character of any proposed or alternative treatment. Moreover, I have a right to understand the anticipated results of my care and other alternatives available to me and any recognized serious health risks or complications that are likely to impact me. I am expected to ask questions when my Provider communicates anticipated benefits, risks, or complications to me, and my failure to ask clarifying questions will be taken to mean that I fully understand the nature and character of my care or that I have voluntarily opted not to be further informed. I also understand that I may withdraw consent for any health care services at any time.

I hereby authorize ICHS to release information needed by my third-party insurance to secure payment for services I receive at ICHS. The following payment information will apply when services are not performed on the Mobile Dental Clinic. ICHS provides sliding scale discount (adjusted for income and household size) for qualified uninsured and patient's out-of-pocket costs after third-party insurance payments. I am expected to pay my fair share of the charges in a timely manner or make payment arrangements with ICHS if I am unable to pay my balance in full. For some services, full payment will be required at the time of visit. I understand that I will not be refused health care due to inability to pay my bill as long as I provide required financial information. However, refusal to pay my fair share of the costs or lack of cooperation to arrange for a payment plan may result in termination of services.

I understand that if I am an adult consenting for the care of a minor patient or an incompetent adult patient, I must have the legal authority to do so. If I am consenting for a minor child, I must be an acknowledged biological parent (i.e. my name is on my child's birth certificate) or adoptive parent (i.e. I have legally adopted the child), and my rights must not have been restricted by a court order (e.g. by terms of a divorce). If I am a family member, relative, caregiver, or other individual consenting for the care of a minor or adult, I do not have the legal authority to consent for health care unless this authority has been expressly granted to me by the patient, the patient's legal representative, a court, or statutory law. If I am acting under authority given to me by a court order or a power of attorney, I may be asked to provide a copy of such documentation, and such documentation must be approved by ICHS, before I can act on another patient's behalf. I further understand that my rights as a personal representative may be restricted if applicable laws allow. For example, minors may be treated as adults and afforded full authority to control their health information if they meet certain conditions and are being treated for a mental illness, a sexually transmitted disease, or reproductive related health issues. I acknowledge these requirements and restrictions.

_____
Translator's Name

_____ _____
Signature Date

( ) copy provided in: _____

_____ _____
Signature (Parent/Guardian if under 18) **Date**

_____ _____
Parent/Guardian's Name (PRINT) **Date**

Parent/Guardian's Date of Birth: _____

Are you consenting for your own health care? ☐Yes; ☐No* (see below)

*Specify your relationship to the patient: ☐ mother; ☐ father; ☐ court-appointed guardian/representative;
☐ other (specify): _____

Declaration of Representative Authority (Relatives Only)

I am a relative responsible for the care of a minor child. I hereby declare and affirm under penalty of perjury pursuant to RCW 9A.72.085 that I have the legal authority to make health care decisions for the minor listed above. I understand that I will not be asked to provide documentation of my legal authority to consent for the minor at this time, unless my Provider has reason to question the validity of this declaration. However, I may be asked to produce supporting documentation at any time. This declaration shall be valid for six (6) months.

Signature: _____ Date: _____

ICHS International Community HEALTH SERVICES

Patient Rights and Responsibility

PATIENT RIGHTS

You have the right to:

- Choose a health care provider that provides you with quality care.
- Receive care in a safe, private, and respectful setting by knowledgeable personnel.
- Receive services in a manner that respects your language, culture and beliefs.
- Receive information about your care and treatment in terms you can understand.
- Receive services without discrimination based on race, color, sex, marital status, sexual orientation, age, creed, religion, ancestry, gender identity, genetic information, use of service animals, national origin, veteran status, citizenship status, or the presence of any sensory, mental or physical disability or the ability to pay.
- Receive information about ICHS hours, providers, services, fees and payment policies in a language that is easy for you to understand.
- Be notified if your care involves the training of healthcare providers.
- Privacy of your healthcare information except as required by law or insurance company contracts.
- Read and receive copies of your medical records within a reasonable amount of time.
- Know that when an emergency occurs and you are transferred to another facility, a responsible person/family member will be notified.
- Request assistance with information on advance directives for your healthcare.
- Be notified in advance to allow you to choose whether or not you would like to participate in experimental clinical research studies.
- Respectfully express dissatisfaction with the care you receive through a patient complaint/grievance policy.

PATIENT RESPONSIBILITIES

You have the responsibilities to:

- Ask questions if you do not understand what you are being told.
- Tell us everything you know about your health history, current health, and any changes in your health.
- Tell us about all medications, herbs, supplements, and over the counter (OTC) medications you may be taking.
- Participate in your care by making decisions, following directions and accepting responsibility for your choices.
- Follow the treatment plan agreed upon with your provider. This includes following instructions of other health care professionals as they carry out the orders of the provider.
- Choose a family member or other person to represent you if you are unable to make your own health care decisions.
- Treat other patients, visitors, volunteers and ICHS staff and property with courtesy and respect.
- Arrive on time for all appointments and let us know in advance you are unable to keep an appointment.
- Provide accurate information for processing any insurance coverage, and to pay any co-payments, co-insurance amounts, and deductibles as requested in a timely manner.
- Inform your provider about any existing advance directive or medical power of attorney.
- Conduct yourself in an appropriate manner while receiving services from ICHS staff or at ICHS facilities and events. Failure to follow instructions from ICHS staff, comply with policies and treatment agreements, or when refusal of treatment prevents the delivery of safe and appropriate care, the relationship with the patient may be terminated with notice.

_____ _____

Patient's Signature/Print Name Date

International Community Health Services
P.O. Box 3007
Seattle, WA 98114-3007
(206) 788-3700

HEALTH HISTORY ☐ Male ☐ Female

Name of Patient: _____ Birthdate: _____

Phone Number: _____ Preferred Language: _____

Address: _____

Ethnicity: ☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ More than one race ☐ Prefer not to list

Name of Physician: _____ Date of last physical: _____

Is the patient now under the care of a physician? YES NO

If yes, for what reason? _____

Is the patient presently taking any medications/drugs/pills? YES NO

If yes, please list:_____

Is the patient allergic (or has an adverse reaction) to any medications? YES NO

If yes, please explain: _____

Is the patient sensitive or allergic to latex? YES NO

Has the patient had any unusual or unexplained reactions during a surgical procedure? YES NO

If yes, please explain: _____

Patient has dental insurance (including Medicaid, SCHIP, etc.) YES NO

Name of Insurance Company: _____

Name of Subscriber: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____ Subscriber's Date of Birth: _____

Effective Date: _____ Expiration Date: _____ Customer Service Phone #: _____

Has the patient ever experienced any of the following? (Please check all that apply.)

Abnormal Blood Pressure	☐	Epilepsy	☐	Osteoporosis	☐
Attention Deficit Disorder (ADD)	☐	Fainting Spells	☐	Prolonged Bleeding	☐
Alcohol Addiction	☐	GI Problems (GERD)	☐	Prosthetic Implants	☐
Anemia	☐	Glaucoma	☐	Psychiatric Care	☐
Arthritis/Rheumatism	☐	Hearing Impaired	☐	Removal of Spleen	☐
Artificial Heart Valve	☐	Heart Disease/Surgery	☐	Rheumatic Fever	☐
Artificial Joint	☐	Heart Murmur	☐	Rheumatic Heart Disease	☐
Asthma	☐	Heart Pace Maker	☐	Sickle Cell Disease	☐
Autoimmune (Lupus/MS)	☐	Hemophilia	☐	Sinus Trouble	☐
Cancer	☐	Hepatitis ☐ A ☐ B ☐ C	☐	Stroke	☐
Radiation Therapy	☐	HIV Positive/AIDS	☐	Thyroid Problem	☐
Chemotherapy	☐	Kidney Problems/Dialysis	☐	Tuberculosis	☐
Cholesterol	☐	Learning Disability	☐	Tumors	☐
Congenital Heart Disease	☐	Liver Disease	☐	Ulcers	☐
Diabetes	☐	Lung Disease	☐	Sexually Transmitted Infection (STI)	☐
Eating Disorder	☐	Mitral Valve Prolapse	☐	Wheel Chair	☐
Recreational Drug Use	☐	Neurological Disorders	☐	Sudden Weight loss/gain	☐
Emphysema	☐	Organ Transplant	☐		

ICHS International Community HEALTH SERVICES

Has the patient had any other serious illness, hospitalization, or accident? YES NO

If yes, please explain: _____

Does the patient currently smoke or use the following tobacco products?

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ None

Has the patient used tobacco in the past? YES NO If yes, how long ago? _____

Does the patient drink alcoholic beverages? YES NO If yes, how much? _____

Are the patient's immunizations up-to-date? YES NO

FEMALE PATIENTS, please circle YES or NO.

Is she pregnant? YES NO Is she breast feeding? YES NO Is she using birth control medications? YES NO

Comments:

DENTAL HISTORY

Date of Last Dental Visit: _____

Please check all that apply to the patient.	**YES**
Do the patient's gums bleed while brushing or flossing?	☐
Are the patient's teeth sensitive to hot or cold liquids/foods?	☐
Are the patient's teeth sensitive to sweet or sour liquids/foods?	☐
Does the patient feel pain to any of his/her teeth?	☐
Does the patient have any sores or lumps in or near his/her mouth?	☐
Has the patient had any head, neck, or jaw injuries?	☐
Does the patient have frequent headaches?	☐
Does the patient clench or grind his/her teeth?	☐
Does the patient bite his/her lips or cheeks frequently?	☐
Has the patient ever experienced any of the following?	☐
☐ Clicking in jaw ☐ Pain (joint, ear, side of face) ☐ Difficulty in opening or closing mouth ☐ Difficulty in chewing	
Has the patient had any orthodontic work?	☐
Has the patient ever had prolonged bleeding following extractions?	☐
Has the patient ever had instruction on the correct method of brushing his/her teeth?	☐
Has the patient ever had instruction on the care of his/her gums?	☐

Comments:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

To comply with the Health Insurance Portability and Accountability Act (HIPAA), Privacy Regulation, ICHS is required to provide you our Notice of Privacy Practices. This is to inform you that we keep a record of the health care services we provide you. You may ask to see or request for a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. For more information, please contact our Medical Records departments at:

Bellevue Clinic	(425) 373-3012
Holly Park Clinic	(206) 788-3541
International District Clinic	(206) 788-3712
Shoreline Clinic	(206) 533-2641

This form will be retained in your medical record.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Printed name of patient Patient's date of birth

_____ _____
Signature of patient or authorized representative (if patient is under 18) Date

_____ _____
Printed name if signed on behalf of patient Relationship to patient

Notation

A copy has been given to patient or authorized representative.

Notice of Privacy Practices

(Effective September 2013)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and our privacy practices with respect to that information. We are required to abide by the terms of the Notice of Privacy Practices currently in effect, but we reserve the right to change these terms at any time. Any changes will be effective immediately and will be available to you on our website (www.ichs.com).

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

For Treatment. We may use or disclose your protected health information to provide you with medical treatment. We may disclose your protected health information to doctors, nurses or other members of our health care team who are involved in your care. For example, your physician may need to consult with specialists about your care. Your protect health information would be shared with them to help understand your health care needs.

For Payment. We may use or disclose your protected health information so that the treatment and services you receive at International Community Health Services ("ICHS" or "we") may be billed to you, an insurance company or third party. For example, we may need to give your health plan information about surgery you received so that your health plan will pay us or reimburse you for the surgery. We will not disclose your protected health information to third party payers without your authorization unless allowed to do so by law. You have a right to request the restriction of the disclosure of your protected health information to a health plan or other party when that information relates solely to a healthcare item or service for which you or another person on your behalf (other than a health plan) has paid us, and we are required to agree to such request.

For Health Care Operations. We may use and disclose your protected health information about you for health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care. For example, we may use health information to assess the quality of the health care services provided to you or to evaluate the performance of our staff.

OTHER ALLOWABLE USES OF YOUR PROTECTED HEALTH INFORMATION WITHOUT REQUIRING YOUR PRIOR AUTHORIZATION

Business Associates. There are some services provided at ICHS through contracts with business associates. Examples include laboratory, external auditors, outside attorneys and others. Whenever an arrangement between a business associate and ICHS involves the use or disclosure of your protected health information, we will have a written agreement that will protect the privacy of your protected health information.

Communication to Entity Assisting with Disaster Relief - We may disclose your protected health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

Appointment Reminders - We may contact you as a reminder that you have an appointment for treatment or health care services at ICHS.

Treatment Alternatives - We may use your protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Research – Under certain circumstances, ICHS may use and disclose population health information for medical research purposes. In most circumstances, we will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are. Before we use or disclose health information for research, the project will have been approved through this research approval process. In most circumstances, we will ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are. We may, however, disclose health information about you to people preparing to conduct a research project as long as the health information does not leave ICHS.

As Required By Law - We will disclose your protected health information when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety - We may use and disclose your protected health information when necessary to prevent a serious threat to your health or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to prevent the threat.

Organ and Tissue Donation - If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans - If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation - We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health - As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Health Oversight Activities - We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes - If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

Law Enforcement - We may disclose your protected health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at ICHS;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors - We may disclose your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities - We may disclose your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

CERTAIN USES AND DISCLOSURES REQUIRING AUTHORIZATION

Most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes, disclosures that constitute a sale of protected health information, and other uses and disclosures of protected health information not covered by this Notice will be made only with your written permission. If you provide ICHS with permission to use or disclose your protected health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Communication with Family and Friends - We may share your protected health information with family members or friends who are involved in your care and/or payment for your care if you tell us that we can do so, or if you do not object to sharing of this information. We may also share relevant information with these persons if, using our professional judgment, we believe that you do not object.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Although your health record is the property of ICHS, your protected health information belongs to you. You have the following rights regarding your protected health information:

Right to this Notice - You have a right to a paper copy of this Notice. You may ask us to give you a copy at any time. You may also obtain a copy of this Notice at our website: **www.ichs.com**.

Right to Inspect and Copy - You have a right to inspect and receive a copy of certain health care information pertaining to you including billing records. You must submit your request in writing to the:

International Community Health Services
Attn: Health Center Manager
PO Box 3007, Seattle WA 98114-3007

If you request a copy of such protected health information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health record, you may request that the denial be reviewed. We will comply with the outcome of the review.

Right to Request Amendment - You have a right to ask that your protected health information be amended by giving a written request to our Health Center Manager.. We have the right to deny this request under certain circumstances. You may write a statement of disagreement if your request is denied. This statement of disagreement will be stored in your health record, and included with any release of your records.

Right to an Accounting of Disclosures - You have the right to receive an accounting of disclosures. This is a record of certain disclosures we made of your protected health information in accordance with law.
You must submit your request in writing to the Health Center Manager. We may charge you for the costs of providing the record. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. The Health Center Manager can be reached at the following address:

International Community Health Services
Attn: Health Center Manager
PO Box 3007, Seattle WA 98114-3007

Right to Request Restriction - You have a right to ask us to restrict certain uses and disclosures of your protected health information. For example, you may request that we limit the protected health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose your protected health information about a surgery you had to a family member or friend. You must submit your request in writing to the Health Center Manager. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse; however, we are not required to agree to a requested restriction.

Right to Request Confidential Communications - You have the right to request that we communicate with you about health matters in a specific way or location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must submit your request in writing to the Health Center Manager. We will not ask you for the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of Breach – You have a right to be notified following a breach of unsecured protected health information.

Complaints

If you believe your privacy rights have been violated, you may contact the ICHS Compliance Officer at 206.788.3658 or submit your complaint in writing to the ICHS Compliance Officer at PO Box 3007; Seattle, WA 98114-3007.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

The quality of your care will not be jeopardized nor will you be subject to any retaliation for filing a complaint.

If you have any questions about this notice please contact the ICHS Compliance Officer at 206.788.3658.