Community Health Care, Inc.
Opening Doors to Health Care

COMMUNITY HEALTH CARE, INC. CONSENT FOR TREATMENT ADULT

Patient _____ Birthdate_____ Chart #_____

I, _____, allow the providers and employees of Community Health Care, Inc. to assess and treat my health needs. This includes anything needed to diagnose me; any photographs that are needed to treat my medical needs, any shots, or any treatments or ordered by Community Health Care, Inc. providers.

- I have been given a copy of the Patient Bill of Rights and Responsibilities and have been able to ask questions about it.

- I have been given a copy of the Notice of Privacy Practices. I can get extra copies of the notice when I ask for one.

- After your visit we give you a written health plan. We are not legally liable for the privacy of your information if you leave it or lose it.

- **I know that I need to update the consent form if changes need to be made. This consent is valid until I tell CHC to cancel it.**

_____ _____
(Signature of Patient/Legal Representative) (Date)

_____ _____
(Witness) (Date)

(Please continue on the backside)

COMMUNICATION WITH FAMILY & OTHERS INVOLVED IN YOUR CARE

Patient _____ Birthdate_____ Chart #_____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, please indicate what type of information may be shared with each individual.

		TYPE OF INFORMATION					
NAME: RELATIONSHIP TO PATIENT:	All	Scheduling/ Appointment	Medical	Billing/ Insurance	Dental	HIV Info	Prescriptions
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐

Specific Instructions or Limitations: _____

_____

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. In order for us to change your information please come in and fill out a new form.

_____ _____

(Patient's Name Printed) (Signature of Patient/Legal Representative)

_____

(Date)