Registration and General Consent

Alcona Citizens for Health, Inc.

I understand that:

- Alcona Citizens for Health, Inc. (AHC) offers care in an integrated (combined) setting, Medical, Behavioral Health, and in some settings Dental and Pharmacy.
- I have the right, as a patient, to be informed about my condition and the recommended medical or diagnostic procedure to be used so that I may make an informed decision whether to undergo suggested treatment after knowing the risk and hazards involved. This is a general consent form where I grant my permission for AHC to perform the evaluation necessary to help identify the appropriate potential treatment for me.
- Some health information is specially protected. I must give consent to share this information in some cases. This information includes HIV/AIDS status, sexually transmitted infections (STIs), tuberculosis (TB), Hepatitis B, genetic information, and behavioral health, and substance use disorder information.
- My health records are electronic and includes all the services I receive at AHC and all specially protected health information.
- AHC has put in place protections to keep the privacy and accuracy of all my medical information including alcohol and substance use disorder treatment.
- These protections follow all state and federal privacy laws including Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code.
- I may ask AHC to limit the use of my Protected Health Information (PHI).
- My Treatment may be photographed, or video/audio recorded for medical or educational purposes. Images that identify me will only be released if I give consent or if needed for my treatment.
- My provider will treat only what they are capable of treating. I may ask for another opinion from a supervising provider or a different provider.
- I may ask to be seen by a specific provider.
- AHC takes part in teaching programs, bringing students into AHC offices. I must consent to have a student examine me. All care provided by a student is under direct supervision of their AHC supervisor.
- I may choose not to receive any services recommended by my provider unless it is required by a court order.
- AHC may inform me if I am eligible to take part in research studies. My decision to take part in research will not affect my care and is voluntary.
- AHC offers secure online access to my electronic medical records through the patient portal. This access is voluntary.
- AHC may tell my family or friends about my location and condition if there is an emergency or disaster.
- I have the right to discuss with AHC about the purposes, potential risks, and benefits of any testing or treatment plans recommended. If I have any concerns regarding any test or treatment recommended by our clinician, AHC encourages me to ask questions.
- I voluntary authorize the AHC providers, and all designees as deemed necessary, to perform reasonable and necessary testing and suggest treatment for the condition which has brought me to seek care to AHC.

Telehealth Treatment

I understand that:

- Telehealth is the delivery of services using interactive technologies (including but not limited to video, phone, test, apps, and email) between my provider and me who are not in the same physical location. This service my not involve direct face to face communication.
- The technologies used in telehealth include network and software security measures to protect the privacy of my information communicated via any electronic network. However small, there are still risks with internet-based software and connections, including risks with hackers or other internet security breaches.
- I will need access to, and familiarity with, the appropriate technology to participate in the service provided. I must have an email to receive a link to access the telehealth service and access to a device with an internet connection. The email correspondence for the telehealth session is not encrypted.
- All services are documented in my health record.
- Paperwork exchange will be provided through electronic means or through the mail.
- Details of my medical history and personal health information may be discussed with myself and other providers using interactive video, audio, or other telecommunication technology.
- I will be told if there are additional people in the location with the provider and I will be able to provide consent before an additional person is present.
- It is my responsibility to maintain privacy on my end of communication. It is important to be mindful of individuals in the same room or area that may hear the conversations in the visit.
- There are risks, not limited to, disruption of service due to technical difficulties. It is my responsibility to contact the AHC clinic if the session is disconnected.
- If a need for direct, face to face services occurs, it is my responsibility to contact my health center for a face-to-face appointment.
- My Participation in the telehealth process is voluntary, I may decline any telehealth services at any time without jeopardizing my access to future care, services, and benefits.
- An emergency plan will be created in preparation for emergency situations, disruption of service, or other communications. I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based medical services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital in my immediate area.
- I must consent to a telehealth visit, and the consent may be expressed verbally in the presence of an AHC employee.
- Telehealth sessions are not recorded.

Notice of Privacy Practice Acknowledgement

I have read and understand the notice of Privacy Practices.

I understand that:

- Following HIPAA, AHC will use and share my PHI for:
  - Treatment of my health condition(s) and providing continuous (ongoing) care
  - Payment for my health services
  - Research
  - Routine processes including quality improvement, accreditation, educational purposes or other disclosures as required by law.
- The Notice of Privacy Practices is available to me at the location(s) I receive my health care services on the AHC website.

The Electronic Health Records and My Protected Health Information (PHI)
I consent to:

- AHC working with other health care providers to coordinate, manage and give health care to me.
- AHC using and sharing my PHI and specialty health information through written, verbal, or electronic communication for the purpose of:
  - Prescriptions with my preferred pharmacy
  - Referrals to specialists
  - Coordination of care
  - Checking current insurance status
  - Pre-admission or continues length of stay certification
  - Other purposes needed to improve quality of health care I receive; for example, avoiding unnecessary or repeat testing
- AHC using and sharing my PHI and specially protected health information for purposes of payment to:
- Insurance companies
- Managed care organizations
- My employer (if I am injured at work)
- State and Federal Government programs like Medicaid and Medicare
- Workers' Compensation programs

The Health Care Exchange and My Protected Health Information

I understand that:

- AHC participates in a Health Information Exchange (HIE) through MiHIN, who follow all state and federal privacy laws to maintain the security of my protected health information.
- I understand that more information about HIE and MiHIN is available to me at the location(s) I receive my health care services and on the AHC website.

I consent to:

- Participate in the HIE. I understand that my entire health record including specially protected information (see second bullet in "I consent to" Electronic Health Record and My Protected Health Information section for information on specially protect information).

Assignment of Benefits and Financial Responsibility

I understand that:

- If I do not assign benefits, I will be billed the full cost of all services including behavioral health and substance use disorder treatment.
- If my insurance does not pay for all or part of my services, I may be responsible to pay for those services.
- I must follow AHC's financial policies to continue my care at AHC.
- I understand that if insurance information is in my record, the insurance plan will be billed.
- If there is no insurance listed in the record and the patient has not requested other arrangements in advance, payment is expected at the time of service.
- Payment may be made by cash, check, money order, VISA, Discover, or Master Card.
- A fee will be charged to the issuer for all checks returned for insufficient funds. This fee will be set periodically by AHC.
- AHC offers a reduced (Sliding) Fee program for those who qualify. Please inquire if further information is needed.

- No one will be refused services based on their ability to pay. Ability to pay is determined by the Federal Poverty Guidelines which are published yearly.
- If arrangements have been made to pay installments, and the terms of the agreement are not met, collection procedures may be initiated according to the AHC's Policy. All unpaid balances are subject to AHC's collections policies.
- The adult/guardian sign this registration form for a minor child are responsible for full payment of services rendered to the aid minor child.
- AHC accepts payments from most major insurance companies. All insurance information must be provided to AHC within 30 days from the date of service or the charges will become the responsibility of the patient/guardian. AHC reserves the right to add or delete insurance plans from whom payment will be accepted.
- If AHC is unable to obtain payment/explanation of benefit from your insurance company within 60 days from the date of billing all charges will become the responsibility of the patient or the parent/guardian of a minor child.

I give permission for:

- My insurance to pay my benefits directly to AHC.

Communicating with Me

I understand that:

- AHC will leave messages at the phone number I give for appointment reminders, prescription refills, and scheduling information for referrals and/or testing.
- AHC may also send me text messages or emails using the contact information that I give.

I agree to all the above and understand this consent will remain in effect for 12 months.

Patient Full Name: _____ Date of Birth: _____

Patient/Parent/Legal Guardian Signature_____

Today's Date: _____

If a signature is not obtained, staff must sign form in good faith efforts that they have attempted to obtain signature.

Staff Signature_____

Today's Date: _____

This form is compliant with HIPAA privacy regulations, 45 CFR Parts 160 and 164 as modified January 1, 2025, 42 CFR Part 2, PA 258 of 1974 and MCL 330.1748 and PA 368 of 1978, MCL333.1101 et seq and PA 129 of 2014, MCL330.1141a.