KNOX CLINIC
Your Mid Coast Health Net

Consent to Treatment & Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____
(Print)

The Knox Clinic ("Clinic") is a health clinic that provides patient-centered integrated medical care for physical and mental health, including dental services, to patients regardless of age, sex, sexual orientation, gender identity, color, rate, ethnicity, creed, national origin, religion, physical or mental disability or veteran status. The Clinic uses electronic health records that includes having all of your health information in one place. To give you the best care possible, your Clinic providers may view any portion of your health record relevant to your treatment, which may include your physical or mental | behavioral health records or your dental records.

1. General Consent to Treatment: By signing below, I authorize health care providers at the Clinic to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care (including emergency treatment), services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo any procedure or test, my provider (s) will explain the test or procedure, including the most frequent risks and side effects; the likelihood of success; other options, including the risks and side effects of those alternatives; and information about the risks and benefits of refusing the recommended treatment.

2. Right to Refuse Treatment: In giving my general consent to treatment, I understand that I may refuse any examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my health care provider(s) and that I remain responsible for decision about my own healthcare and the consequences of those decisions.

3. Responsibility of Payment: I understand that I must pay the Clinic for any charges resulting from my treatment. I request that payment of authorized covered benefits be made on my behalf to the Clinic for such services. I understand that in order to verify those benefits the Clinic may release to my health insurance carrier(s) health information about me, including information related to HIV/AIDS, substance abuse (except information limited by law), and mental health treatment.

4. Release of Health Care Information: I understand that, subject to certain conditions, I may ask to limit disclosures, receive confidential information by giving the Clinic an address, phone number or other means of receiving the information, see or obtain copies of protected health information upon written request, and that I have other rights with respect to my health information as set forth in the Notice of Privacy Practices and listed in the Clinic's "Authorization for Release of Health Care Information"

5. Notice of Privacy Practices: I understand that the Clinic must keep my health information confidential, but legally may share information concerning my diagnosis and treatment with other healthcare practitioners and facilities involved in my ongoing care and treatment and may use my information for other purposes including getting paid for services provided to me, coordinating care for me, or for the Clinic's necessary business operations. I understand that a detailed list of allowed uses and disclosures is included in the Clinic's Notice of Privacy Practices. I have been offered a copy of the Clinic's Notice of Privacy Practices and I

   ☐ TOOK A COPY ☐ CHOSE NOT TO TAKE COPY **(please check one)**

6. Signature: By signing below I agree that I have read and understand the information provided above. If I have any questions regarding my consent I will ask my provider before signing this form.

Patient Signature: _____ Date: _____
(If under 18, a parent or legal guardian must sign)
Witness Signature _____ Date: _____