GENERAL CONSENT TO MEDICAL TREATMENT & FINANCIAL AGREEMENT

_____ **(initial here**) A. **CONSENT FOR CARE & TREATMENT**: I consent to the rendering of an examination and treatment by Pathway Health Clinic's employees. I understand that such examination may include a review of my medial history, pelvic examination/testicular exam, breast examination and/or breast health education. I further understand that laboratory tests may be necessary that may include a hemoglobin, urinalysis, Pap smear, pregnancy test, and/or screening for sexually transmitted infections or vaginal infections and/or risk related to particular methods. I have the right to discuss the proposed examination or treatment with the medical staff, and to consent to, or refuse such examination or treatment. I have been advised of the nature and purposes for all procedures associated with my care and treatment and understand and accept the risk involved. I understand that all services are rendered on a voluntary basis; I also have the right to refuse or stop services at any time. No clinic staff persuasion shall be used to force me to accept any form of birth control, abortion, or to participate in the Pathway Health Clinic Program or to receive services from other available programs. All services are strictly confidential and will not be released to anyone without my permission, except as required by law and covered in section B. I understand that I have a right to satisfactory answers to any questions regarding the education that I receive. I also have a right to a language interpreter if any barrier exists.

_____ (**initial here**) B. **AUTHORIZATION FOR RELEASE OF INFORMATION**: I authorize Pathway Health Clinic to release information from my medical record to any health care provider participating in any way in the care of the client and to any person or entity which is or may be liable for all or part of the charges for services received. I understand that following release of medical records or information, Pathway Health Clinic will no longer be responsible for the confidentiality of any documents released in accordance with this authorization. I understand that by written notice to Pathway Health Clinic I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it. Clients understand information may be disclosed in summary, statistical, or other forms without clients consent when the information does not allow individual clients to be identified.

_____ **(initial here**) C. **ASSIGNMENT OF BENEFITS AND CLAIMS**: I hereby authorize payment of benefits by any third-party payer directly to Pathway Health Clinic for services rendered. I also hereby assign to Pathway Health Clinic all claims and causes of action of any kind whatsoever which I may have against an insurance company or other third-party payer or against any other person or entity for payment or reimbursement for goods or services provided by Pathway Health Clinic. I understand that Pathway Health Clinic is not required to exercise these rights but may do so in its sole discretion without any liability for its decision. I further understand that the assignment above does not in any way affect my obligation to pay Pathway Health Clinic charges. **I understand that I am responsible to pay for charges not covered by my private insurance plan.**

_____ **(initial here**) D. **MEDICAID**: If I am eligible for any Medicaid coverage, I agree to notify Pathway Health Clinic of the nature and extent of my coverage at the time of signing this document. If I fail to do so, Pathway Health Clinic may for all purposes consider me to be a "self-pay" patient and I shall be personally responsible to pay for all services. If Pathway Health Clinic later discovers that I qualify for Medicaid, they may opt to treat me as a Medicaid patient, but they shall not be required to do so. I certify that any information given by me now in applying for payment under the Medicaid program(s) is correct, and I authorize release of information as needed to file for benefits. I request that payment of authorized benefits be made on my behalf to Pathway Health Clinic for charges relating to services provided. **I understand that I am responsible to pay for charges not covered by my plan.**

_____ **(initial here**) E**. ACKNOWLEDGE RECIPT OF NOTICE OF PRIVACY PRACTICES**: By signing below, I acknowledge that I was offered a copy of Pathway Health Clinic's Notice of Privacy Practices, HIPAA. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice by contacting the Pathway Health Clinic Executive Director or by requesting one at the Pathway Health Clinic office.

_____ **(initial here**) F. **FINANCIAL AGREEMENT**: In consideration of the services provided, the undersigned agrees to pay all charges to Pathway Health Clinic**. I understand that not all services offered at Pathway Health Clinic qualify for the sliding fee scale.** Each bill is due and payable upon presentation (at time of service) or mailing of same to either the patient and/or the guarantor.

I CERTIFY THAT I UNDERSTAND AND AGREE TO THE PROVISIONS CONTAINED WITHIN THIS AGREEMENT

I voluntarily give permission for examination, testing and treatment by Pathway Health Clinic.

_____ I do **NOT** consent to HIV testing today.

Signature of client or legal representative Date Staff Date

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