CONSENT FOR TREATMENT SERVICES

I authorize **Blackstone Valley Community Health Care** to provide any and all medical and dental procedures, tests, and/or treatment services deemed to be necessary by the Center to myself, my minor child, or individual for whom I am legal guardian/personal agent.

____ _______________ _____________
Patient Name Date of Birth Date

Consent for Payment

I authorize BVCHC to obtain reimbursement from any eligible health insurance coverage for services provided, which are covered under my insurance plan. I understand that BVCHC may be required to provide my insurance plan with certain patient identifying and clinical information, including drug and alcohol information, in order to obtain authorization for treatment and payment for services. I agree to disclose the identity of any other party who may be responsible for paying for the services provided by BVCHC. I understand that my records are protected under the Federal Confidentiality Regulation and under the General Laws of the State of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand payment is expected at the time of service and that I am responsible for reimbursing BVCHC for any co-pays, unmet deductibles, and non-covered services agreed to in the treatment plan. Insurance co-payments and deductibles cannot be waived.

Patient's Rights/Complaint Procedure

I am aware of my rights as a patient of Blackstone Valley Community Health Care and have been provided a copy of my rights and the Center's complaint procedure.

Consent for Uses and Disclosures of Personal Health Information

I understand that all personal health information (PHI) describing history, symptoms, diagnoses, treatment, test results, and plans for treatment can be used for the purpose of:

- Planning care and treatment;
- A means of communication among the professionals who contribute to your care;
- Applying a diagnosis to a bill;
- A means by which third-party payers can verify that services billed were actually provided;
- Routine healthcare operations assessing service delivery and quality of care.

I understand that I have the right to request how (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations and the organization is not required to agree to the request.

____________________________________ ______________ _____________________

Patient/Legal Guardian Signature Date Witness Signature