PLACE PATIENT STICKER HERE
Medical Record #
Name:

Consent for Treatment and Authorization to Bill Insurance

Open Door Health Center (ODHC) is dedicated to providing primary care, dental and behavioral health services to Southern Minnesota residents. Because physical and emotional problems often go together, we believe the best care is given when health care providers work together. ODHC patients may be referred to providers from other health care specialties outside of ODHC or within the ODHC treatment team; members of the treatment team will share clinical information with each other as is clinically necessary.

Patient shall call 24 hours in advance if Patient cannot keep his/her appointment. Patient may need to reschedule if arrival time is more than 15 minutes after the start of the appointment.

Information about Patient will NOT be given to anyone outside ODHC, including family and friends, unless Patient (parent or legal guardian, if a minor) gives written permission. Patient may consent to release of his/her information if Patient is age 16 or older for behavioral care and 18 or older for primary or dental care. However, we may release Patient's information to others without the Patient's permission if: 1) Patient poses a threat to him/herself or others; 2) Patient is unable to protect him/herself from risk of harm; 3) Patient is in the legal custody of a government agency or facility; 4) there is evidence of child abuse; 5) Patient's clinical records are requested under court order including a subpoena to which Patient does not object promptly; 6) as stated in HIPAA Notice of Privacy Practices.

There are fees for all services, and Patient should pay on the day Patient is seen. Health insurance policies may cover a portion of the fees and staff will help Patient in making claims. Patient shall tell ODHC staff about changes in financial status including insurance.

The professional staff of ODHC will depend on statements made by Patient, Patient's medical history, and other information to evaluate his/her condition and decide on the best treatment. The evaluation and treatment of children and adolescents often requires the involvement of the parent(s) and/or other family members.

Some services at Open Door Health Center may involve the use of lab services provided by Quest. The care team may include a RN Care Coordinator, Behavioral Health Consultant, Community Health Worker, and Insurance Enrollment.

Our health center providers follow best practices when making diagnosis, determining the course of treatment and possible outcomes. Any questions about the benefits, risks, available options, or the limits of confidentiality should be directed to the treatment staff.

In treating patients, studies including x-rays, laboratory tests, EKGs or psychological tests may be warranted. There are risks involved in taking any medications and any questions about medications will be answered by the medical staff. Patient accepts the risks of medication and other treatment.

I understand, that if I am 16 years of age or older, I may consent for mental health services, substance use disorder screening and treatment, sexually transmitted disease (STD) screening and treatment, and/or pregnancy screening; if I am 18 years of age or older, I may consent for all other health services; otherwise my parent or legal guardian will need to consent for services. By signing this form, (parent or legal guardian signature, if required) I agree that I have read or had this form read and/or explained to me, that I understand it and that any questions I asked have been answered. I understand that I agree to be truthful in providing information.

Thus, I hereby ask, agree, and consent to evaluation, treatment and payment for authorized insurance benefits payable to ODHC for any services provided for myself and/or my child as set forth above, including any studies or procedures that ODHC professional staff decide are necessary or appropriate. If signing as parent or guardian, I hereby represent and warrant that I am legally empowered and entitled to make such decisions.

I have received or was offered and declined a notice of privacy practices.

_____ _____

Patient's or Guardian's Signature Date

_____

Type or print name

_____ _____

Witness Date