Public Health

For internal use only:
Insert Patient info. or attach label
Patient Name:___________________
DOB: __________________________
MRN#:_________________________

ACKNOWLEDGEMENT AND CONSENT FORM
for Public Health Services

By signing this form, I consent to the use or disclosure of my protected health information by Durham County Department of Public Health (DCoDPH) for the purpose of providing treatment to me, obtaining payment for my health care bills, or to conduct DCoDPH's health care operations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that DCoDPH has taken action in reliance upon my prior consent.

My "protected health information" means any of my written and oral health information, including my demographic data that can be used to identify me, that has been created or received by DCoDPH, and that relates to my past, present or future physical or mental health or condition.

I. **_________ ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES. By initialing this section,** I hereby acknowledge that the "Notice of Privacy Practices" for DCoDPH was displayed for me to read and review. I understand that I may request a copy of the Notice at any time during or after my visit at DCoDPH. I understand that I may contact the person named in the Notice if I have questions about the content of the Notice. Additionally, I understand that I may also access a copy of the Notice on the DCoDPH website at: https://www.dcopublichealth.org/home/showdocument?id=32618. DCoDPH reserves the right to change the privacy practices that are described in the Notice of Privacy Practices without prior notice. I understand that I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing DCoDPH's website.

II. **________ CONSENT FOR TREATMENT. By initialing this section,** I hereby certify that in the event medical treatment is necessary, such treatment shall be fully explained to me, to my satisfaction, by the DCoDPH medical personnel and/or other health care provider/s present and providing treatment during my visit. I hereby consent to said treatment as explained to me by the DCoDPH medical and healthcare personnel and any other medical personnel providing services at the time of my visit.

III. **_______ CONSENT FOR TELEHEALTH. By initialing this section,** I understand that telehealth technology will be used to connect an individual with a provider and that such consultation may be conducted by videoconferencing, video images, and/or by telephone conference. I hereby consent to DCoDPH providing health care services to me via telehealth. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting the Durham County Health Department.

_______ INSURANCE/ PAYMENT INFORMATION. By initialing this section, I hereby authorize and request the payment for treatment through Medicaid, Medicare, and any other Third Party benefits that I am entitled to be paid directly to DCoDPH for all services furnished to me by any of the providers employed or contracted with by that facility. I hereby consent to the release of my income information by DCoDPH to any of the providers and laboratories, employed or contracted with by DCoDPH and said information may be used to determine my eligibility for free or reduced cost services, as well as other billing purposes. I hereby certify that the information provided concerning my income is true and complete and that I have

no income other than what I have provided. I understand that I am responsible for any charges not covered by this assignment or charges that are specifically excluded from coverage by Medicaid, Medicare or participating private insurance programs. Upon penalties prescribed by law, I hereby affirm that to the best of my knowledge and belief, this income statement is true and correct. I understand that the information may be checked by a state reviewer and I agree to provide the financial records required to carry out this review. **I understand that my employer may be asked to verify information concerning my income. I also understand that if I do not provide proof of income on the date of service, I will be billed at 100% of the visit. I understand that I will have 7 days to present this documentation in order to base the previous 100% charge to a sliding fee. I also understand that if the bill is not paid within 60 days, DCoDPH can send my account to NC Debt Setoff. I assign insurance benefits to DCoDPH. I agree to pay DCoDPH any money I receive from insurance for services which DCoDPH provided for me. I understand, as a part of my visit, some laboratory services may be necessary that DCoDPH is unable to complete in the clinic. I also understand I will receive a bill from the testing agency, and I will be responsible for the cost of these test(s).**

I understand that this consent and acknowledgment is given in advance of any specific diagnosis or treatment and that these services are voluntary and that I have the right to refuse these services. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force unless revoked in writing and will not affect any actions that were taken prior to receiving my revocation.

My signature indicates that I agree to all of the initialed items above.

____
Signature of Patient/ Parent or Legal Guardian

____
Date