FALLON PAIUTE-SHOSHONE TRIBE
FALLON TRIBAL HEALTH CENTER
1001 Rio Vista Drive • Fallon, Nevada 89406-5463
Tel 775-423-3634 • Fax 775-423-2287 • www.fthcnv.com

CONSENT FOR CARE AND TREATMENT

Patient Registration Form 300-2 (Rev. Apr 2023)

PATIENT NAME (FULL LEGAL NAME) _____ HEALTH RECORD NUMBER (HRN) _____

CONSENT FOR ROUTINE MEDICAL CARE AND TREATMENT

Patient's Initials _____

The Fallon Tribal Health Center (FTHC) and its employees are hereby authorized to collect medical history information, obtain vital signs and perform other routine procedures for purposes of providing care to you. I understand that my agreement to accept these services is called General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking X-rays, use of local anesthesia and other non-invasive procedures. You have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency, or extraordinary circumstances. Under emergency circumstances, we will take necessary and available actions to meet your medical needs.

AUTHORIZATION FOR THE TREATMENT OF A MINOR

Patient's Initials (if applicable) _____

It is understood that this authorizes the FTHC to provide medical treatment to the above-named minor child. This authorization includes the consent for examination, treatment, medical and/or surgical diagnosis, medication prescription, and/or immunizations (as required by applicable law). It is further acknowledged that informed consent for the FTHC provision of immunizations may be revoked by the parent(s) /person having legal custody or guardianship at any time, however, the revocation must be in writing and acknowledged by receipt of the FTHC.

LIMITS OF CONFIDENTIALITY

Patient's Initials _____

Information discussed during health visits at the FTHC is held confidential and not shared with anyone without written permission except under the following conditions:

1. If the patient threatens suicide.
2. If the patient threatens to harm another person, including murder, assault, or other physical harm.
3. If the patient reports suspected child abuse, including but not limited to physical beatings or sexual abuse.
4. If the patient reports abuse of the elderly.
5. If the patient reports sexual exploitation by another healthcare or mental health professional.

Federal Law mandates that healthcare and mental health care professionals may need to report these situations to the proper authorities and/or agencies (see 42 U.S.C. 290ee-3, for Federal Laws and CCR part 2). Communication between you and your healthcare or mental health professional will otherwise be confidential under Federal Law.

CONSENT TO DISCLOSURE OF INFORMATION

Patient's Initials _____

Patient medical records and billing information are created and retained by the FTHC and are accessible to its personnel and medical staff for use in my care. The FTHC personnel and physicians may use and disclose medical information for its business operations and to any other physician or health care personnel involved in providing care. Safeguards are in place to discourage improper access. The FTHC is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or administrator of a self-insured employer group which is responsible for any part of the FTHC's charges and to any health care provider who is or is expected to become involved with a patient's care. These disclosures are for treatment or payment purposes. By signing this agreement, you are consenting to such disclosure. You may revoke this consent in writing addressed to the FTHC, except to the extent we have already acted in reliance on it.

PRECERTIFICATION POLICY

Patient's Initials _____

You understand that the FTHC will assist with insurance precertification requirements which are the responsibility of the policyholder and/or practice but will not assume responsibility for precertification or any impact which it may have on the insurance payment.

ASSIGNMENT OF INSURANCE BENEFITS

Patient's Initials _____

You agree that insurance benefits for the FTHC charges payable to the insured are to be made payable to the FTHC and that insurance benefits for services provided by healthcare providers in the practice setting otherwise payable to the insured are to be made payable to the healthcare provider(s) responsible for your care.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Initials _____

A complete description of how your medical information will be used and disclosed by the FTHC is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this Acknowledgment. The Notice is posted throughout our office, and you will be given a copy to read.

PATIENT/CLIENT ACKNOWLEDGEMENT

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of this Consent for Care and Treatment. I further certify that I am the patient or legally authorized by the patient to accept the terms of this form, and I know and understand the contents thereof. **This Consent for Care and Treatment will remain until revoked in writing.**

_____ _____

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN DATE SIGNED