WHITMAN-WALKER HEALTH

Services Provided to Minors - General Consent and Acknowledgement

In order for you to become a patient, we need your consent to provide you with care. We also need you to acknowledge that we have provided you with certain important information and documents. If you have any questions about any of this information or need help completing this form, please do not hesitate to ask a member of our staff. It is important to us that you feel comfortable with all of this information. By signing, you are indicating that you understand the information below, have been given a chance to ask questions, and are giving your consent for yourself (if 13 years old or older), or your child/minor for whom you have legal responsibility.

GENERAL CONSENT TO TREAT

I voluntarily authorize the providers of WWH to provide such care, treatment, or services as are considered necessary and advisable for me. I understand that while any care, treatment, or service recommended by WWH, including any testing for Sexually Transmitted Infections (STIs), will be based on established medical criteria, and that such care, treatments, or services have both potential benefits and risks. WWH will explain the relevant benefits and risks to me before providing any intervention, treatment, or service. I understand that I have a right to refuse care, treatment, or services at any time to the extent the law allows. If there is an emergency and I am not able to provide consent, I understand WWH may provide care, treatment, or services without waiting for me to consent. I understand that some services may require me to sign another Informed Consent to Treatment, which I will be asked to complete before WWH provides such services to me. All information given me and, in particular, all estimates made as to the likelihood of occurrence of risks or as to the prospects of success, represent the best professional judgment of my health care provider. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there can be no guarantee, either express or implied, as to the success or other results of the medical treatment. Finally, I acknowledge that students or residents being trained as doctors, nurses, therapists and other health care providers may assist in caring for me under the supervision of WWH licensed providers.

NOTICE OF PRIVACY PRACTICES

I have been given a copy of WWH's Notice of Privacy Practices and I understand that WWH is required by law to protect my protected health information, and will not share it with anyone outside of WWH without my consent unless permitted or required by law or any ethical requirements that may be applicable. I understand that these circumstances include but are not limited to situations where WWH assesses me to be a danger to myself or to someone else, where WWH is mandated to report abuse or violence, or where WWH is required to disclose information about me under a court order or Federal, state, local law. For example, if I test positive for an STI and refuse to seek treatment, WWH is required by law to inform my parent or guardian about any treatment needed for the STI. I acknowledge that if I am eligible for insurance coverage and claims are generated and submitted to an insurance carrier for medical or behavioral health services provided to me, it is likely that an explanation of benefits (EOB) form will be sent to my parent or guardian that will include my protected health information.

INTEGRATED MODEL OF CARE

WWH offers a wide variety of services to its patients. I understand that in order for me to get the best service for my needs, programs within WWH may share information concerning my health to ensure the quality and continuity of my care across service areas. For example, WWH may share my demographic information, medical and other service referrals, and other non-clinical information with WWH Legal Services to allow for legal referrals and for scheduling purposes. The details of my health records will only be shared with WWH lawyers if I agree for them to take my legal case.

MY HEALTH GPS

By signing below I am agreeing to be a participant in the My Health GPS Program at WWH, and I understand that my WWH health care providers and other people outside of WWH will share information about me in order to provide me with better care. I have received a separate information sheet from WWH that describes the My Health GPS Program in more detail and includes a list of partners in the Program. I understand that WWH will share my protected health information with partners in the My Health GPS Program. By checking this box and signing below, I am agreeing that all current and future partners in the My Health GPS Program are allowed to access, use and share my protected health information, including information about illnesses, injuries, test results, x-rays, medicines and other health information that predates the date when I sign this form. I also understand that the health information shared may include alcohol or drug use records, family planning services like birth control and abortion; inherited diseases, HIV/AIDs, mental health conditions and STIs. I am aware that there is no obligation for me to participate in the Program and that I may withdraw from the Program at any time. My decision not to participate in the Program or to withdraw from the Program will have no impact on my health care at WWH.

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HEALTH INFORMATION EXCHANGE

I understand that WWH participates in certain health information exchanges with other hospitals and health centers located in the metropolitan area, including the Chesapeake Regional Information System for our Patients (CRISP) and the Capital Partners in Care Health Information Exchange (CPC-HIE). I have been informed that my health information, including limited information relating to mental health and substance abuse services that I may receive at WWH, will be shared with these exchanges. Notes from my psychiatrist, mental health therapist or addiction counselor will not be shared, but diagnosis codes and a history of my visits will be shared. I understand that information about me will be shared with providers and public health officials outside of WWH for treatment purposes, in order to better coordinate my care and to assist providers and public health officials in making more informed decisions. I have been advised by WWH that I have the right to "opt-out" of these health information exchanges at any time. I understand that I can request a copy of the "opt-out" form from WWH and direct WWH to disable access to my health information, except to the extent that disclosure of such information is permitted or mandated by law.

PATIENT RIGHTS AND RESPONSIBILITIES AND PATIENT HANDBOOK

I have been given a copy of the WWH Patient Rights and Responsibilities document and understand that both the Rights and the Responsibilities laid out in that document must govern my interactions at WWH. I also understand that WWH and I are responsible for adhering to the Rights and Responsibilities. I understand that I have a right to file a complaint or grievance with WWH, as described in WWH's Patient Handbook. The Patient Handbook contains information about being a patient at WWH, including services that WWH offers, hours of operation, and contact information for services. I have been provided with a copy of the Patient Handbook.

RELEASE OF INFORMATION FOR BILLING AND CONSENT TO REIMBURSE

I know that WWH needs to send parts of my protected health information to organizations that help pay for my care, such as my health insurance company or an organization that grants money to WWH. I allow WWH to release the relevant parts of my records so that my care can be paid for. If I do not feel comfortable with this, then I understand that I may request WWH to not disclose protected health information to my health insurance company. I understand that WWH must grant such requests if I elect to pay for my care in full at the time I receive the service.

CONSENT TO ELECTRONIC COMMUNICATIONS

Patients are permitted to request electronic communications with WWH. I understand that e-communications could include information about my medical care and treatment such as appointments, billing information, prescriptions, test results and recommended treatment. This is an optional means of communication which can be restricted upon my request by submitting an **E-communications Opt-Out Form** available from Client Services or on the WWH website. I acknowledge that the most secure means of e-communications with WWH is by use of WWH's Patient Portal or by protected/encrypted electronic messages. Any other method of e-communication presents a greater risk of violation of my privacy because the communications may be seen by third parties or sent to unintended parties. By signing below, I am requesting and consenting to unencrypted e-communications with the understanding that WWH will, to the best of its ability, limit the information included in such e-communications to the minimum necessary.

ACKNOWLEDGMENT OF DUTY TO REIMBURSE WWH FOR HEALTH CARE SERVICES

I understand that WWH offers a Sliding Fee Scale of discounted or free health care items and services to uninsured or underinsured individuals who are deemed unable to pay based on their level of income when those services are within the scope of WWH's Federally Qualified Health Center Services. In order to be eligible for WWH's Sliding Fee Scale of discounted or free services, I will need to provide WWH's Public Benefits and Insurance Navigation team with documents establishing that I am uninsured or underinsured and meet income eligibility requirements. If I do not provide the required documents to WWH, I am responsible for paying my fees for medical, behavioral health, or dental services received at WWH in full at the time of service. I also understand that if I am an insured patient with insurance WWH does not accept, or an insured patient with a copay obligation who fails to pay fees or copays due at the time of service, I will not be scheduled for future appointments until such time as my outstanding fees or copays are paid.

By signing my name below, I acknowledge that I have read, and fully understand, each of the separate paragraphs set forth above and attest that I am a minor age 13 or above, or that I am the parent or legal guardian of a minor age 13 or above.

Printed Name of Patient:	**Date of Birth:**
Signature: *(If applicable)*	**Date:**
Printed Name of Parent/Legal Guardian:	
Relationship to Patient:	
Signature:	**Date:**