SEL HEALTH CLINIC

# ACKNOWLEDGMENT AND CONSENT

*At the SEL Clinic, we take pride in providing excellent patient care in line with our SEL Values and Principles of Operation. We look forward to serving you!*

**Acknowledgment of Receipt of Notice of Privacy Practices**

The Health Insurance Portability and Accountability Act (HIPAA) requires us to give you a notice of our privacy practices and to acknowledge your receipt of the notice. What is the Notice of Privacy Practices? The Notice of Privacy Practices explains how your protected health information may be used or disclosed by us. In addition, it explains your rights with regard to your protected health information as well as our legal responsibilities. You have the right to review our Notice of Privacy Practices before you sign this Consent. We have the right to revise this Notice at any time. The Genetic Information and Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. Genetic information includes:

- An individual's family medical history
- Results of an individual's or family member's genetic tests
- The fact that an individual or an individual's family member sought or received genetic services
- Genetic information of a fetus carried by an individual or an individual's family member
- An embryo lawfully held by an individual or family member receiving assistive reproductive services

Therefore, you do not have to answer any family history questions or provide any other genetic information on our medical documents in order to be seen by our provider(s). If you choose to complete the family history questions or provide other genetic information, our providers will use this information to assess and treat you. We will not share your family medical history or other genetic information with your employer. Family medical history information may be used in de-identified reports to your employer, but we will never share any information with your personal name or identifying information.

Patient Name _____ Date of Birth _____
Legal Last Name Legal First Name MI MO DAY YYYY

Preferred Name _____ Phone (  ) _____ Email _____
Email is used only for the secured **Patient Portal**

Address _____ City/State _____ Zip _____

Pharmacy _____

**Sex at Birth**
- ☐ Male
- ☐ Female

**Gender Identity**
- ☐ Male
- ☐ Female
- ☐ Nonbinary
- ☐ Transgender MTF
- ☐ Transgender FTM

**Ethnicity**
- ☐ Hispanic or Latina/o/x
- ☐ Not Hispanic

**Race Category (Check all that apply)**
- ☐ American Indian
- ☐ Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Asian
- ☐ Other

Emergency Contact Name _____ Relationship / Phone _____

Other Insurance Company _____ Subscriber/Group # _____

**Care for Minors:** List other authorized persons that can bring this minor in for medical care below.

Name _____ Relationship _____ Phone (  ) _____

I understand I may revoke this authorization and consent in writing, except insofar as health information has been disclosed prior to my revocation. If I do so, I understand the SEL Health Clinic has the right to decline to provide me further medical care.

TURN OVER

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**Consent to Release Information**

The SEL Health Clinic can share my medical information with others listed below (i.e., significant other, primary doctor, and family):

Primary Doctor's Office and Location

Other Individuals (i.e. significant other or family)

Name (First and last) Phone # Relationship to patient

**Consent to Treatment _____ (Initial)**

I consent to and authorize the medical provider and all healthcare professionals and staff who may be involved in my care (or the care of the minor under my legal care) to provide such examinations, diagnosis, care, and treatment considered necessary or advisable by my healthcare providers.

**Release of Health Information _____ (Initial)**

I, the undersigned, certify that the patient is covered by SEL's insurance and is eligible to receive services at the SEL Health Clinic. I also authorize my provider to disclose my health information necessary to carry out treatment, payment, or healthcare operations.

**Audio and Photo Documentation of Care _____ (Initial)**

I authorize the taking and storing of photograph and audio recordings of myself or this minor under my care and documents that include photographs (such as a driver's license or other identification) as determined by my healthcare providers, including photographs of wounds, and for other medical reasons. I also understand that pictures and audio recordings taken to document care are owned by the SEL Health Clinic, but I am allowed to access them. The photos and audio recordings will be securely stored in the medical record and protected by law and only released in accordance with the Notice of Privacy Practices.

**Reschedule, Cancellation, and Late Policy _____ (Initial)**

I understand when I make an appointment time is saved for me with a provider. I will inform the SEL Health Clinic at least 24 hours prior if I am unable to make my scheduled appointment. After two cancellations or missed appointments without proper notice, all future appointments will be canceled. If I am 10 or more minutes late to my scheduled appointment, I understand my appointment will be canceled, and may be rescheduled. I understand that it is my responsibility as the patient to reschedule any canceled appointments.

**Patient Termination Policy _____ (Initial)**

The SEL Health Clinic reserves the right to terminate patient relationships under the following conditions: non-compliance with treatment instructions, repeated canceled appointments, verbal abuse or other inappropriate behavior towards staff or other patients, or other unacceptable conduct or behavior which adversely affects a patient's treatment, the treatment of other patients, or the operations of the SEL Health Clinic.

**Pharmacy Consent _____ (Initial)**

The SEL Health Clinic has my permission to view active and historic prescriptions from external sources for the coordination of care.

**Signature of Acknowledgment of Receipt of Notice of Privacy Practices, GINA, Consent to Treatment, Release of Health Information and Other SEL policies listed above.** Health Clinic documents are available on our website at selfamilycenter.com/HealthClinic and at the front desk. *Please Note:* In certain circumstances, in accordance with State and Federal laws, parent/guardian permission may not be needed for adolescents being seen for concerns of "heightened sensitivity," such as STD testing, family planning, Pap smears, mental health, etc.

Patient Name (Print) _____

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____