STATEMENT OF CONSENT FOR TREATMENT: I hereby voluntarily consent for evaluation and treatment by the staff of the Hot Springs Health Program (HSHP) and their agents. If the patient is a minor who I am responsible for and/or the parent or legal guardian, I consent to evaluation and treatment of my child. These services may include diagnostic, therapeutic, imaging, and laboratory services. Further, I understand that specific and separate consent forms may be requested from me prior to any non-routine treatment that is not an emergency. I am aware that the practice of medicine and behavioral health are not an exact science; no guarantees have been made to me about the results of treatments, examinations, or services.

TELEHEALTH: I consent to receiving care via telephone (audio only), telehealth (audio/visual) or patient portal when medically necessary and clinically appropriate to exchange medical information between me and the provider, or between one provider and another provider.

FINANCIAL AGREEMENT: Subject to applicable law and the terms and conditions of any applicable contract between HSHP and a third-party payer, I agree to be financially responsible and obligated to pay HSHP for any balance not paid under the "Assignment of Benefits" paragraph listed below. By request of the Hot Springs Health Program, Inc., payment is expected at time of service, unless other arrangements have been made in advance. Hot Springs Health Program is not contracted and does not accept assignment with all insurance companies. Insurance will be filed as a courtesy for our patients. I also agree that I am responsible for any applicable copayments, coinsurance, or deductibles.

ASSIGNMENT OF BENEFITS: I hereby assign to HSHP all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third party payers of an amount not exceeding HSHP's regular and customary charges for health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third parties. I also authorize release of medical information to my insurance company if needed to determine eligibility of these benefits or benefits of related services. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by HSHP to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third-party payer. I understand that my current insurance must be on file with HSHP for my insurance to be billed and, as such, I will be expected to present my insurance card at each visit to verify my insurance coverage. If I do not provide HSHP with insurance information, I will be considered a self-pay patient and obligated to pay all fees associated with services rendered.

CONSENT TO RETRIEVE MEDICAL INFORMATION: I authorize Hot Springs Health Program to download my medication history and pharmacy benefits into my account from a pharmacy clearinghouse. Utilizing this method is the best way to obtain the most up to date information so that your healthcare provider can deliver the best care to you.

PRIVACY PRACTICES NOTIFICATION: I have had the opportunity to view or obtain a copy of the Hot Springs Health Program's Notice of Privacy Practices as required by the federal Health Insurance Portability and Accountability Act.

COLLABORATIVE CONSENT: Hot Springs Health Program is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at http://www.ochin.org. As a business associate of Hot Springs Health Program, OCHIN supplies information technology and related services to Hot Springs Health Program and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by Hot Springs Health Program with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

The personal health information may include past, present and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

If you have any questions or concerns related to these consents or rights and responsibilities, please inform Front Desk at the Medical Center.

X _____ _____

Signature of Patient/Guardian/Legal Representative **Date**