UNICARE COMMUNITY HEALTH CENTER, INC.
GENERAL CONSENT FOR TREATMENT

CONSENT FOR TREATMENT: The undersigned patient, responsible relative and/or patient's legal representative hereby voluntarily consent and authorizes Unicare Community Health Center ("Unicare"), its affiliated physicians, dentists, nurse practitioners, case managers, licensed therapists, medical assistants, nursing staff, dental assistants , hygienist, psychologists, psychiatrists, and physicians assistants to provide such care and treatment, including but not limited to physical or mental examination, diagnostic tests, medical procedures and medications which may now or during the course of the patient's care be deemed advisable or necessary. I understand that in emergency situations, it may be necessary or advisable for Unicare to perform services and/or procedures that may not be fully discussed with the patient (or responsible relative and/or patient's legal representative) in advance. I consent to these services and/or procedures under those circumstances. I am aware that the practice of medicine is not an exact science and I further acknowledge that no guarantees have been made regarding the effect of any treatment or procedure on any medical condition.

RIGHT TO REFUSE TREATMENT: I understand that I have the right to make informed decisions regarding all care and treatments, and that I may ask the health care professional to explain anything that is not understood. This right includes the right to refuse any treatments.

TEACHING PROGRAMS: Unicare may participate or contract with training institutions for teaching medical students, interns, residents, healing arts students (i.e.: nursing, hygienists, x-ray technicians, dental assistants) and post-graduate students. I understand that these trainees may participate in the care provided under the supervision of qualified and licensed personnel.

RELEASE OF INFORMATION: To the extent necessary to determine liability for payment and to obtain reimbursement, Unicare may disclose portions of the patient's financial and medical records to any person, corporation or to any agent of any such person or corporation which is or may be liable for all or any portion of Unicare's charges, including but not limited to insurance companies, employers, health service plans or Worker's Compensation carriers. Unicare may also make pertinent information available to government agencies and other health care providers as necessary to insure continuity of care and availability of health care services for the patient and the patient's family.

ASSIGNMENT OF HEALTH BENEFITS: I hereby authorize the insurance company to pay by check made out to Unicare and mail directly to Unicare the medical/dental, behavioral health and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. I understand that insurance copayment/co-insurance, non- covered services and patient liability amounts are my responsibility.

FINANCIAL AGREEMENT: The undersigned agrees to pay, whether he or she signs as agent or patient, the charges incurred at Unicare in accordance with Unicare's regular rates and terms. I understand that if I am a member of a Health Maintenance Organization (HMO) and I have not secured an authorization for payment of my services, I will be held financially responsible for all unauthorized and non-covered services.

ADVANCE DIRECTIVES: Adults 18 and older have the right to: (a) give direction about their future medical care or (b) designate a patient representative to make medical decisions for them if they lose individual decision-making capacity. I understand that I have the right to change my instructions at a later date and I understand that information about advance directives is available to me upon request.

I have executed an Advance Directive: ☐ Yes ☐ No *(If yes, please provide us with a copy)*

I would like further information: ☐ Yes ☐ No

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CONSENT TO FOLLOW-UP: I understand that Unicare may contact me regarding my medical/dental status and to ask questions concerning satisfaction regarding services received. The purpose of this information is to assure the continuity of care and to provide Unicare with pertinent statistical information.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) NOTICE OF PRIVACY PRACTICES:
I have received information about the HIPAA Notice of Privacy Practices (NPP) and acknowledge my receipt of this documentation. I am the patient or I am authorized to sign this form. I have received a copy of it and accept its terms.

I have read, understood and agree with all of the above statements (initials) _____

_____
PATIENT NAME (PRINT)

_____
PATIENT SIGNATURE

_____
DATE

_____
PARENT/LEGAL GUARDIAN NAME (PRINT)

_____
PARENT/LEGAL GUARDIAN SIGNATURE

_____
DATE

_____
WITNESS NAME (PRINT)

_____
WITNESS SIGNATURE

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