LINCOLN COMMUNITY HEALTH CENTER INC
CONSENT FOR TREATMENT AND NOTICE OF PRIVACY PRACTICE

Patient Name: _____D.O.B:_____ MRN: _____

The following information is to be completed by the patient or the patient's legally authorized representative/parent.

I consent to medical treatment which may include appropriate x-rays, immunizations, and lab work, including HIV testing, for me or for the patient for whom I am the parent or legally authorized representative.

I understand that I am responsible for **ALL CHARGES INCURRED**, regardless of my insurance status. I authorize my insurance provider to pay Lincoln Community Health Center for services rendered. I agree to pay for all co-payments and charges that are not covered by my insurance carrier. I understand that Lincoln Community Health Center may share patient health information with Freedom House, Durham County Human Services, Local Access to Coordinated Healthcare (LATCH), Project Access of Durham County (PADC), and with other service providers in the N.C. Ryan White CAREWare system; if applicable, according to federal and state law for treatment, payment, and operations.

I certify that the income and other registration information provided by me to Lincoln Community Health Center staff for the purpose of receiving services is accurate. I further understand that my health records are subject to federal audit, and that if Lincoln Community Health Center determines I have falsified this information, I will be notified and then dropped as a registrant and may no longer receive services at Lincoln Community Health Center, except in a life threatening emergency.

I consent to receive text messages for appointment reminders. You will be able to opt out at any time.

By signing this statement, I (Print name) _____certify that I have read and
(Legal name)
fully understand the contents of this statement.

Furthermore, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices and The Patient Rights and Responsibilities.

Patient's Signature_____ Date: _____
(If minor, guardian's signature)

Relationship of Legally Authorized Representative to Patient: _____

Witness Signature: _____ Date: _____

HIMS: 9/2005;
Revised: 4/2009, 2/2015, 9/2015, 7/19