

Treatment, Payment and Data Agreement



Patient Name: _____ Date of Birth: _____

- I hereby give my consent and authorize Outer Cape Health Services to treat any medical or mental health condition providing that the care provider has explained my condition to me, the treatment procedures and alternative methods of treating my condition. The care provider has discussed with me foreseeable risks of the above stated treatment and that there may be undesirable results.
- I understand that Outer Cape Health Services operates a primary care practice that integrates behavioral health services, which means behavioral health staff are part of my medical team and experience, and that being seen by a behavioral health provider through primary care may result in additional charges to my insurance. This may also result in an additional copayment or coinsurance. I acknowledge that in cases of insufficient coverage, I will be held responsible for the remaining balance.
- I authorize examination and treatment for this and all following medical or mental health visits.
- I have carefully read and fully understand this Informed Consent Form and all of my questions have been adequately answered.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I accept full responsibility for payment of services and/or for securing necessary primary care referrals or pre-approvals for medical visits. If applicable, I understand that I have an obligation to obtain a referral for specialist services from my primary care physician (PCP) prior to having services rendered. I acknowledge that if the appropriate referral/authorizations are not on file at the time services are rendered, that I am financially responsible for any charges denied by my health insurance carrier as a result.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that Outer Cape Health Services may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.
- I certify that the above information is true and correct. I have received a copy of Outer Cape's Notice of Privacy Practices (HIPAA) and Patient Rights and Responsibilities.

Patient Signature _____ Date _____

General Information: Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education.

The patient and/or family, as appropriate, are given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

Outer Cape Health is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Outer Cape Health, OCHIN supplies information technology and related services to Outer Cape Health 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 health information may be shared by Outer Cape Health with other OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

The information in your medical record is confidential and is protected under both Federal and Massachusetts laws. Your written consent will be required for release of information except in those certain circumstances where consent is not legally required.