COOK CLINIC

TREATMENT CONSENT FORM

Patient Name: _____ **Patient DOB:** _____

Purpose of this Consent Form: This form is provided to patients of the COOK Family Health Center, Inc. (the "Clinic"). We want to let you know about the care and treatment that you will receive from the Clinic, and to obtain your consent to allow us to provide your care. In the case of patients under the age of 18, or other individuals who may not be capable of making informed choices about their healthcare, we provide this form to their parents, guardians or caregivers to evaluate and sign on behalf of the patient.

General Consent and Conditions of Treatment: I consent to the treatment that will be provided by the Clinic primary care providers, as well as their assistants and other Clinic staff members. I understand that a medical record will be prepared and maintained about me by the Clinic, and that I am entitled to obtain a copy of my medical record by signing a Medical Records Authorization Form provided by the Clinic for that purpose.

Student Participation: I understand that the Clinic participates in the education of healthcare students. I can decline their participation in my care at anytime.

Communication With Health Care Providers: To safeguard my health information, I understand that the Clinic's practice is to convey test results to patients by phone, mail (to the address provided by the patient or caregiver), patient portal or in person. I understand that the Clinic's policies do not permit discussions about my health information, or transmission of my test results via email, since email is generally not a secure method of communication. I understand that I always have the option to call the Clinic or make an appointment to come in to discuss my test results or health issues with a provider.

Emergency Situations: I understand that in emergency situations, it may be necessary or advisable for the Clinic to perform services and/or procedures that may not be fully discussed with me (or my parent or caregiver) in advance. I consent to these services and/or procedures under those circumstances.

Billing and Collection: I give the Clinic permission to share my information with my insurance company for purposes of seeking payment, as well as any third-parties that may be involved in billing or collection services for the Clinic. If I don't want certain information shared with my insurance company, I have the right to notify the Clinic before any billing takes place, but I understand that I must also pay in full at the time the treatment is provided to avoid sharing the information with my insurance company.

Work-Related Treatments or Disabilities: I understand that the Clinic does not treat work-related injuries or illnesses, and that I should see my HR representative for further instructions. I understand that if I am to require treatment for credentialing, some of my information will be shared with my employer in order to validate my credentials. I also understand that if I request special accommodations based upon a disability, a limited amount of my medical information may be shared with my employer, to the extent warranted to evaluate or confirm my disability.

Authentication: I understand that the Clinic will require patients to provide identification in connection with visits to the Clinic or in connection with any telephone calls in which personal information may be requested. This helps the Clinic ensure that it is not divulging personal information nor treating an unauthorized person. If I cannot provide the necessary identification, I may not be able to receive treatment or receive the information that I am seeking from my medical record until I am able to satisfy the Clinic's authentication requirements. Such documents will include my valid driver's license and/or a picture I.D. from my employer.

Personal Belongings: I understand that the Clinic takes steps to ensure that the waiting room and other areas of the Clinic are safeguarded. However, I understand that I am solely responsible for any personal belongings that I bring with me to the Clinic, including jewelry and other valuables.

Notice of Privacy Practices: By signing this form, I acknowledge receipt of the Clinic's Notice of Privacy Practices.

Validity of Consent: I understand that this consent form shall be valid as long as I am a participant of the Cook Group Health Plan as an active employee, spouse of an employee, family member of an employee, or otherwise. I have the right to withdraw my consent at any time. If I choose to do so, I must provide that withdrawal in writing, to the Clinic. The withdrawal of consent will only apply after it is received and not to any information for which I previously provided consent.

I HAVE READ OR HAD READ TO ME THIS CONSENT FORM, AND UNDERSTAND AND ACCEPT ITS TERMS.

_____	_____
Print Name of Patient	Relationship of Individual Signing Form to Patient (i.e., patient, parent, guardian, caregiver)

_____	_____	_____
Signature	Date	Witness (Clinic Staff Member)