Municipality of Anchorage
Public Health Clinic
825 L Street
Anchorage, Alaska 99501

Patient Name: _____ **Date of Birth:** _____ **MR#:** _____

TREATMENT CONSENT, PAYMENT AGREEMENT, AND INSURANCE RELEASE (all patients)

1. I hereby consent to receive medical and related services from the staff of the Municipality of Anchorage, Anchorage Health Department (AHD) Clinical Services Division: Disease Prevention and Control (DPC) and Reproductive Health Clinic (RHC), and understand these services may include: health education; review of medical history; medical exam; screening and administration of immunizations; screening and treatment of Tuberculosis; screening for cervical cancer; screening, testing and treatment for communicable diseases including sexually transmitted disease and HIV; and referrals for care not provided by the program.

2. I understand that I have the right to receive free language interpreter services. I understand that I must tell the staff if these services will be helpful to my understanding of the written or spoken information given during my health care visits.

3. I understand that I will be provided information about the test(s), procedure(s), treatment(s), and contraceptive method(s) prior to any of these services being provided. I understand this information will include the benefits, risks, possible problems or complications and alternative choices. I understand that I should ask questions about anything I do not understand.

4. I know that is my choice whether or not to receive any of these services. I know that at any time, I can change my mind about receiving services through the MOA AHD Clinical Services Division. No guarantee has been given to me as to the results that may be obtained from any services that I receive.

5. I also understand that my medical records will receive confidential treatment. My medical records can be disclosed to others only with my written consent, or as otherwise required by law such as reporting child abuse and reporting certain diseases. If tests are taken for certain sexually transmitted diseases, reporting of positive results from those tests to public health agencies is required by law.

6. If my visit is covered by insurance or other third party payers, I authorize the AHD Clinical Services Division to release medical information necessary to determine benefits payable under this claim.

7. I assign payment directly to the AHD Clinical Services Division for all insurance benefits otherwise payable to me for medical treatment rendered by the clinic. I understand that I am financially responsible for charges not paid by this assignment and that I/the patient will assist in the collection of my/the patient's insurance should there be any delay in payment. I understand I am financially responsible for this bill according to my pay category regardless of insurance coverage.

8. I understand that services will not be denied due to an inability to pay.

9. I will not hold the AHD Clinical Services Division responsible if they are unable to locate me using the contact information I have provided.

10. I understand that the AHD Clinical Services Division does not provide after-hours care. If I have a medical problem when the clinic is closed, I understand that I should contact my usual medical provider or, in the event of an emergency, I should seek care at the nearest hospital emergency department.

11. I have read this consent form or it has been read to me, and I understand the contents. If I have questions, I know to ask the AHD Clinical Services Division clinic staff for help.

HIPPA PRIVACY COMPLIANCE AND HITECH ACT PRACTICES

I have read and received the Municipality of Anchorage, Anchorage Health Department, Clinical Services Division HIPAA Privacy Compliance and HITECH Act Practices document. **Initial:** _____

Signature of patient/guardian: _____ **Date:** _____

Print Name: _____

Relationship to patient: _____

Municipality of Anchorage
Department of Health and Human Services
Clinical Services Division

Notice of HIPAA Privacy Practices and HITECH Act Practices For Protected Health Information Effective Date: September 23, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

This office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Uses of Your Health Information for Treatment Purposes:
We will use your health information to make decisions about the provisions, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Use of Your Health Information for Payment Purposes:
We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes and related healthcare data processing through our system. If you pay for your care or treatment completely out of pocket with no use of insurance, you may restrict the disclosure of your health information for payment.

Use of Your Information for Health Care Operations:
Your health records may be used in our business planning and development operations, including quality improvements in our methods of operation and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities and arranging for legal and auditing functions. Your explicit authorization is required to release your health information for the purposes of marketing, or the sale of information.

There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we may be required to report certain agencies information concerning communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may contact you from time to time to provide appointment reminders or information about treatment. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others.

Emergencies:
We may use and disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practical after the delivery of treatment. If we are required by law or as a matter of necessity to treat you and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other persons or entity without your specific authorization, which may be revoked at any time. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney, or to educational authorities, without your written consent.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Clinical Services Division. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restrictions.

- Receive a limited accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization disclosure incidental to another permissible use or disclosure and otherwise allowed by law.

- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our clinic;

- Request that you be allowed to inspect, request a copy your health record and billing record or request amendments to your health records – you may exercise this right by delivering the request to our clinic;

- Appeal a denial of access to your protected health information, except in certain circumstances;

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our clinic, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact our clinic in person or in writing, during regular, business hours. We will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The Clinical Services Division is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Notify you immediately if we receive information that there has been a breach involving your health information.
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

You may file a written complaint if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer at the Municipality of Anchorage, Department of Health and Human Services or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. More information is available about complaints at the government's web site: http://www.hhs.gov/ocr/hipaa.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

All questions concerning this Notice or requests made pursuant to it should be addressed to:
Department of Health & Human Services, Clinical Services Division Privacy Officer
PO Box 196650
Anchorage, AK 99519.