Alsea Rural Health Care, Inc.

PO Box 229, Alsea, Oregon 97324

ACKNOWLEDGEMENT OF CLINIC PRIVACY PRACTICES AND CONSENT TO TREATMENT

PRIVACY POLICY

I understand that Alsea Rural Health Care, Inc. ("This Practice") will use and disclose **health information** about me.

I understand that my **health information** my include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examination, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies / others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support my provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my right regarding my health information.

I understand that the Notice of Privacy Practices may be revised periodically, and that I am entitled to receive a copy of any revision. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practice in effect will be available upon request.

_____ _____

Client signature date

CONSENT TO EXAMINATION AND TREATMENT

I am voluntarily accepting health services including physical examination, assessment, education, counseling, treatment and referral.

I understand that I may change my mind at any time and I have the right not to have the treatment or procedure done. If I say no, I can still obtain other services at the Alsea Clinic. I hold harmless and release the clinic and staff from any and all liability that comes from my not having the services I am asked to have.

I understand that clinic services include 24 hour care through back up services of Philomath Family Medicine during the hours that the Alsea Clinic is not open. In case of medical emergency, I understand that I need to dial 911 or go to an emergency room, and that I will do so at my own expense.

If I am unhappy with the service that I am receiving, I am aware that I may file a complaint.

_____ _____

Client signature date