Salt River Pima-Maricopa Indian Community
Health and Human Services Department

General Consent for Services

CONSENT FOR EVALUATION AND TREATMENT: I hereby voluntarily consent to services, programs, and care provided by Salt River Pima Maricopa Indian Community Health and Human Services Department (SRPMIC HHS) to perform reasonable and necessary medical examinations, testing, and treatment. My consent continues, even after specific diagnosis has been made and treatment recommended, and I understand that I may be asked to sign a separate informed consent form for certain treatments or procedures.

I understand that during the course of treatment, healthcare workers may be exposed to the patients' blood and/or body fluids, increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the healthcare worker.

I understand that SRPMIC HHS is a teaching facility and medical, nursing, physician assistant, dental, and behavioral health students are frequently part of the patient care team. Under the supervision of the healthcare provider, I consent to having students, interns, residents, etc. to participate in my medical or behavioral healthcare.

I also understand that, if I so choose, I have the right to refuse students, interns, residents, etc. in participating as part of my care team.

I understand that this consent will be valid and remain in effect as long as I obtain services, participate in programs, or receive care from SRPMIC HHS. In order to withdraw this consent, I must provide written notice to RPHC-HIM@srpmic-nsn.gov. By withdrawing consent, I will no longer be able to receive services, participate in programs, or receive any treatments provided SRPMIC HHS.

Patient Initials: _________

CONSENT TO TELEHEALTH: I hereby agree to receive healthcare services provided by SRPMIC HHS via telehealth and understand there are potential risks to using technology, including service disruptions, interception, and technical difficulties. I understand that I have the right to refuse to participate or decide to stop participating in a telehealth visit, and that my refusal will not affect my right to future care or treatment.

I consent to receive telehealth services provided by SRPMIC HHS: **Yes** or **No** (Please Circle)
Patient Initials: _________

CONSENT TO USE OR DISCLOSURE OF HEALTH INFORMATION: I hereby authorize the SRPMIC HHS to use or disclose my protected health information acquired in the course of my care, participation in programs, and/or treatment to any SRPMIC HHS employees, contractors, or agents for the purposes of healthcare treatment, payment, and healthcare operations, in accordance with applicable law. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to SRPMIC HHS staff involved in my care; and to other healthcare providers for treatment activities. This authorization does not include disclosure of any substance use disorder records, which are protected by 42 C.F.R. Part 2, unless use and disclosure of such information is otherwise allowed by applicable law without my consent. I understand that the SRPMIC may use and disclose my protected health information without needing my consent when authorized under applicable law, as described in more detail in the SRPMIC's Notice of Privacy Practices.

Patient Initials: _________

CONSENT TO PROVIDE CERTAIN MEDICAL INFORMATION BY VOICEMAIL: I give my consent for SRPMIC staff to leave specific information such as appointment times/days, prescriptions, etcetera, on my voicemail at the phone number(s) provided on my Patient Registration Form. I understand that it is my responsibility to keep my contact information up to date and to inform HHS staff when my contact information has changed.

Document Version and Approval History
Reviewed and Approved by Legal on 3/8/2024 by Hobbs Strauss and OGC on 4/16
Reviewed and Approved by HHS Policy committee on 4/12/2024
Version 1.2 Last Revision 3/22/2024

I consent to transmission of the above medical information by voicemail: Yes or **No** (Please Circle)
Patient Initials: _________

CONSENT TO RECEIVE TEXT MESSAGES REGARDING MEDICAL CARE: In order to provide you with the best possible care, we occasionally send text messages to our patients about their health care treatment and appointment reminders. By initialing below, I give my consent for SRPMIC HHS staff to text message my cell phone number provided on my Patient Registration Form with specific information such as appointment times/days, prescriptions and/or treatment related needs. Although this may include protected health information (PHI), staff will only send the minimum information necessary. I understand that it is my responsibility to keep my contact information up to date and to inform HHS staff when my contact information has changed. I also understand that I may opt out of text messaging at any time by updating this form to "no" below.

I consent to SRPMIC HHS sending text messages to my cell phone which may include the above medical information:
Yes or **No** (Please Circle)

Patient Initials: _________

REQUEST OF RECORDS: I hereby authorize SRPMIC HHS to request my medical records from previous healthcare providers in order to be fully knowledgeable of my medical history. I agree to complete any required Release of Information forms from previous providers to support these requests as needed or requested by SRPMIC HHS.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to SRPMIC HHS of any health care benefits payable to me under the conditions of my policy for services rendered. This authorization is not limited to private health insurance but may include other sources such as Medicare and Medicaid, Liability claims and/or reimbursable insurance for any services I receive.

NON-BENEFICIARY FINANCIAL AGREEMENT: SRPMIC HHS does not charge for direct care clinical services provided to those persons who meet eligibility requirements in the SRPMIC Eligibility of Services Policy, but will bill any available third-party payor. A copy of the policy can be requested by emailing RPHC-HIM@srpmic-nsn.gov.

If I or my minor child are not considered an eligible beneficiary under the SRPMIC HHS' policies implementing such laws, I understand and agree with the following: In consideration for the SRPMIC HHS services rendered to me or my minor child, I am responsible to pay for such services in accordance with the regular rates. Any cost denied by third-party payors, such as Medicaid, Medicare or private insurance companies, or other responsible party, including co-payments and deductibles, will be my responsibility. SRPMIC does not charge for services to those enrolled in a federally recognized tribe.

PURCHASED/REFERRED CARE: I understand that Purchased/Referred Care Program (PRC) is not an entitlement program and a referral from SRPMIC HHS does not imply the care will be paid. Even if I or my minor child are eligible for PRC, I understand that I must meet requirements for PRC payment to be authorized by the SRPMIC HHS PRC program, including but not limited to notification, medical priority, and use of alternate resources before any PRC payment. More information in regards to our PRC program is available on RPHC.org. For PRC eligibility questions, please call 480-278-RPHC (7742).

Patient Initials: _________

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PATIENT/CLIENT SATISFACTION: I understand that I may be contacted by SRPMIC Health and Human Services Department for feedback on services provided to me by a Provider. I also understand that I can complete a Patient/Client Satisfaction Survey at any time by clicking on the Patient/Client Satisfaction Survey link on the bottom of the www.rphc.org page.

AGREEMENT: MY SIGNATURE INDICATES THAT I UNDERSTAND AND AGREE TO ALL OF THE PROVISIONS CONTAINED IN THIS GENERAL CONSENT FOR SERVICES FORM.

_______________	_______________	_______________	_______________
Patient Name (Print)	Medical Record Number	Patient Signature	Date

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Patient DOB

If applicable:

_______________	_______________	_______________
Parent/Guardian Name (Print)	Parent/Guardian Signature	Date

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