GREATER PORTLAND HEALTH
CARING FOR THE WHOLE COMMUNITY

GENERAL CONSENT TO TREATMENT

180 Park Avenue Portland Maine 04102
P. (207) 874-2141 F. (207) 874-2164

Patient Name _____ **Date of Birth**_____

Greater Portland Health ("GPH") is a community health center that provides integrated medical care for physical and behavioral health, including HIV/AIDS and dental services, to patients regardless of age, sex, sexual orientation, gender identity, color, race, ethnicity, creed, national origin, religion, physical or mental disability, or veteran status. GPH uses an electronic health record that includes all of your medical information in one place. In order to give you the best care possible, your GPH providers may view any portion of your medical record relevant to your treatment, which may include your physical, mental health, substance use and/or dental records.

1. **General Consent to Treatment:** By signing below, I authorize health care providers at GPH to conduct examinations, diagnostic tests and procedures to assess my health care conditions, and to provide care (including emergency treatment), services or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo any procedures or tests, my provider(s) will explain the potential benefits, risks, or side effects, including potential problems that might occur during recovery, the likelihood of success, other options including relevant risks or side effects to those alternatives, as well as information about possible results of not choosing to undergo the recommended treatment.

2. **Right to Refuse Treatment:** In giving my general consent to treatment, I understand that I may refuse any examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my health care provider(s) and that I remain responsible for decisions about my own healthcare and the consequences of those decisions.

3. **Responsibility of Payment:** I understand that I must pay GPH for any charges resulting from my treatment. I request that payment of authorized covered benefits be made on my behalf to GPH for such services. I understand GPH may release health information about me including information related to HIV/AIDS, substance abuse (except information limited by law), and mental health treatment to my health insurance carrier(s) in order to verify those benefits.

4. **Release of Health Care Information:** I understand that, subject to certain conditions, I may ask to limit disclosures, receive confidential information by giving GPH an address, phone number or other means of receiving the information, see or obtain copies of my protected health information upon written request, and that I have other rights with respect to my health information as set forth in the Notice of Privacy Practices.

5. **Notice of Privacy Practices:** I understand that GPH must keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, coordinating care for me, or for GPH's necessary internal operations.

6. **Insurance**: If I have active insurance coverage, I need to make sure my insurance plan has my GPH primary care provider (PCP) listed for proper billing and specialty care access. I understand that GPH has the right to contact my insurance plan provider to provide updated information if the primary care provider listed is not correct.

7. **HealthInfoNet:** HealthInfoNet is a secure, standardized electronic system where health care providers around the state of Maine can share important patient information, giving them the tools needed to make more informed treatment decisions. This is an opt-out program. If you would like to learn more, or opt-out, please ask any one of our Patient Service Representatives at the front desk.

8. **Rules for Proper Behavior:** GPH must be a safe and respectful environment for everyone – clients, staff, visitors and volunteers. Any behavior which makes the clinic space unsafe, abusive, or threatening is unacceptable. Such behaviors will result in appropriate actions by GPH including collaborative care contract and possible termination from the practice.

9. **Grievance rights**: I am aware of my grievance rights as a patient as outlined in Greater Portland Health's Admin 210 Grievance Handling Policy.

10. **Signature:** By signing below I agree that I have read and understand the information provided above. If I have any questions regarding my consent I will ask my provider before signing this form.

Patient Signature_____ **Date** _____

(If under 18, a parent or legal guardian must sign)