PillarHealth
YOUR LOCAL HEALTH CENTER

Consent to Treatment and Payment Authorization

Consent To Evaluation and/or Treatment:

I, for myself (or the patient named below), hereby consent to, and authorize evaluation, testing, and/or treatment, (e.g., medical, dental, behavioral health) which may include the performance of examinations, treatments, therapy, counseling, diagnostic procedures, medical procedures, and dental procedures which the providers at Kenosha Community Health Center (KCHC) / Pillar Health have advised me of and deemed clinically (medical, dental, behavioral health) appropriate and/or necessary. I understand that I am expected to participate in the discussion regarding my treatment plan and I plan to participate in the ongoing creation and revision of this plan as needed.

I understand that health care providers in training may, under the supervision of appropriate personnel, participate in my treatment. Treatment will be conducted within the boundaries of Wisconsin Law for Medical, Dental, Dental Hygiene, Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.

I understand that before receiving treatment, which may include medications and/or vaccinations, I will be provided with specific, complete, and accurate information regarding the proposed treatment, including information on the way the treatment is to be administered, benefits, side effects and risks, alternative treatment modes, and the probable consequences of not receiving treatment. I understand that all immunizations will be entered into the Wisconsin Immunization Registry (WIR). I will have time to study the information or to seek additional information concerning the proposed treatment or services. If the proposed treatment includes controlled substances, I understand that the medications will not be filled early and will not be replaced if lost or stolen. I understand that I have the right to withdraw informed consent at any time, in writing.

I understand that my provider may make diagnostic and treatment recommendations with which I do not agree. I understand that KCHC / Pillar Health cannot guarantee results from the evaluation and/or treatment. However, there will be clear documentation of justifications for the level of functioning, goals, and objectives for continuing or discontinuing treatment.

I understand that this consent to evaluate and/or treat will expire 12 months from the date of signature, unless otherwise specified.

Consent for Telehealth

To better serve the needs of the community, healthcare services are available by interactive video communications using MyChart Virtual Visit. This may assist in the evaluation, diagnosis, management and treatment of several health care needs. This process is referred to as a "virtual visit", "telemedicine" or "telehealth." This means that you can log on to MyChart from home and be evaluated and treated by a health care provider or specialist from another location, such as a clinic. Since this may be different than the type of consultation with which you are familiar, it is important that you understand and agree to the following statements: 1) The consulting health care provider or specialist will be at a different location from me I will consent to the virtual visit from home. 2) I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, and the clinician or specialist. I will give my verbal permission prior to the entry of the additional personnel. 3) The provider will keep a record of the entry of the additional personnel. 4) I

understand that I have the option to refuse telehealth service at any time without affecting the right to future care or treatment and without risk losing benefits. I do not have to answer any questions that I consider to be inappropriate or unwilling to have heard from other people. 5) I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person. **6) I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.**

Confidentiality, Harm, and Inquiry:
Information from my evaluation and/or treatment is contained in a confidential record at KCHC / Pillar Health, and I consent to disclosure for use by KCHC / Pillar Health staff for the purpose of continuity of care. Per Wisconsin mental health law, information provided will be kept confidential with the following exceptions: 1) If I am deemed to present a danger to myself or others; 2) If concerns about possible elder or child (under 18 years old) abuse or neglect; 3) If a court order is issued to obtain records; 4) Internal consultation for coordination of care; 5) Anonymous internal research purpose; and 6) for billing purposes.

Interpreter Services:
I understand that I have the right to an interpreter (sign or spoken language), if necessary.

Patient Handbook
I understand that I can access the information that has been given to me in the Patient Handbook upon request at any time.

Content included in the Patient Handbook includes:

- Billing, Payment, Referral, and Registration Information
- Patient Rights & Responsibilities
- Financial Responsibilities
- Discount Drug Pricing and Medication Refills
- Medication Policy
- Missed Appointments (No-Show) & Double-Booking Appointments
- Reasons for Patient Dismal
- Patient Centered Medical Home {PCMH) Agreement
- Consumer Notice of Health Information Practices (HIPAA)
- Notice of Privacy Practices
- Sliding Fee Schedule

Payment:
I understand that I am responsible for my own bill. As a courtesy, KCHC / Pillar Health will submit charges to my insurance carrier. I am responsible for any charges not covered by insurance, including co-payments and deductibles. If I have no insurance, I will be required to set up payment arrangements with KCHC / Pillar Health's Patient Access Representative II/III (Financial Counselor).

Fees are based on the length or type of evaluation or treatment, which are determined by the nature of the service. I will be given the opportunity to discuss my insurance coverage with a - Patient Access Representative II/III prior to my appointment(s). I am responsible for keeping KCHC / Pillar Health updated about any insurance changes.

PillarHealth
YOUR LOCAL HEALTH CENTER

I hereby agree to pay in full any balance on my account in accordance with the KCHC / Pillar Health payment and credit policies, which may include reasonable attorney's fees. The balance due includes provisions set by my insurance company such as co-payments, deductibles, and "usual and customary" allowance. KCHC / Pillar Health reserves the right to change fees and policies without notice.

I understand that if my account balance is over 90 days old, KCHC / Pillar Health may send my account to a debt collection company who may contact me to collect this balance and make other collection efforts.

Authorization of Payment:
I further authorize payment of any health insurance benefits directly to Kenosha Community Health Center (KCHC) / Pillar Health for services rendered to me or my dependent. This authorization applies to any insurance benefit that was in effect at the time the services were provided.

Signatures:
By my signature below, I acknowledge that I have read, understand, and agree to be bound by the terms of this consent form. I have had the opportunity to ask questions, and my questions have been satisfactorily answered. If I am the patient or the parent, legal guardian, or authorized representative, I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment for myself or for the patient.

Patient Signature

Parent / Guardian Signature