Consent for Treatment, Payment & Notification

I hereby consent to the following:

1. **Consent to Treatment**: a medical examination which may include a physical examination, dental, pediatric, laboratory, behavioral/mental health and other diagnostic examinations; the advisability and necessity of such examination to be determined by physicians, ancillary providers, clinical staff, behavioral health specialist, mental health therapists or contracted medical providers of Tiburcio Vasquez Health Center, Inc. (TVHC). Coordination of care, and discussion may include medical and dental conditions, medications, treatment and information related to behavioral/mental health, tobacco, alcohol/drug and HIV references. The administration of all necessary outpatient medical, surgical, and dental treatments and prescriptions, included but not limited to immunizations, vaccinations, inoculations and anesthetics as deemed necessary by a medical provider or dentist.

2. **Assignment and Payment of Insurance Benefits**: to meet financial obligations, I agree to pay for services rendered. The fee will be determined in accordance with TVHC policies and regulations. I give permission to TVHC to bill and collect payment directly from third party payers, such as but not limited to insurance companies, Medicare and Medi-cal. To release and provide in writing, such information from my medical, behavioral/mental health and/or dental records that may be necessary for continuity of medical care at any other health facility operated by TVHC.

    - *I acknowledge that I have received a copy of TVHC's Notice of Privacy Practice and Patient Rights and Responsibilities.*
    - *I understand that this authorization will remain in effect until it is revoked in writing.*

3. **Notification:** to notify me via phone or text messaging of medical-related messages including appointment reminders, follow-ups, and nutrition information for medical, dental, behavioral or other ancillary services at TVHC. I understand that I am responsible for any costs from my cellular phone provider associated with receiving these text messages. I may stop receiving text messages at any time by replying "STOP". I understand that TVHC may evaluate this messaging approach from time to time to determine if it is working well. Additionally, I understand that the revocation will not apply to information that has already been released in response to this authorization.

Signatures:

_____ _____ _____/_____/_____

Patient/Representative Name | Patient/Representative Signature | Date

If Representative, please state relationship: _____

Certification of Translator:

I, the undersigned, certified that I have:

- Transmitted the above information and advice presented orally to the above-named patient.
- Read the consent form and explained its contents to the above-named patient; and
- Determined to the best of my knowledge and belief, that the above-named patient understood what has been presented.

_____ _____ _____/_____/_____

Translator Signature | Print Name | Date