HAMILTON COUNTY PUBLIC HEALTH NURSING SERVICE

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Informed Consent for Purposes of Treatment, Payment, and Healthcare Operations

Patient/Client Name: _____ Date of Birth: _____

Patient/Client SSN# _____-_____-_____

Address: _____

Insurer: _____ ID#:_____

I, _____, consent to the department and its representatives to provide treatment, obtain payment and conduct health care operations. (If the authorizer is a legal representative, attach a copy of the document that proves your legal right to consent). I understand that my treatment will consist of:

_____

Furthermore, I understand that my condition may change and that my plan of car may be modified to meet and changes in my health care needs.

Prior to signing this consent, I have had the opportunity to review the Department's Notice of Privacy Practices that describes my rights and the Departments duties with respect to my protected health information. The Department's Notice is also displayed in the front lobby that is located at the above address of the Nursing Department. The Department reserves the right to change the privacy practices in the Notice. I may obtain a revised notice by calling the Department. A revised notice will either be sent in the mail or delivered during a regularly scheduled home visit.

I authorize the Department to submit charges and if necessary, health information for my insurance carrier to consider payment for my services.

I hereby request admission to the Department and consent to the care and treatment outlined above and as ordered by my physician. My signature also confirms that I have received a copy and have had the opportunity to ask questions and fully understand the explanation give to me about the consent and Notice.

Signature: _____ Date: _____

Witness: _____

Reason for Authorize Representative's Signature: _____