Community Health Centers, Inc.
110 S Woodland St
Winter Garden, FL 34787
(407) 905-8827 (352) 314-7400
WWW.CHCFL.ORG

Consolidated Consent Form

I, _____ acknowledge by checking each box that I have read and/or been given a copy of the following documents:

- ☐ Payment Agreement
- ☐ Notice of Privacy Practices
- ☐ Medical/Dental Home Booklet
- ☐ Summary of Florida Patient Bill of Rights & Responsibilities
- ☐ Financial Practices & Procedures
- ☐ Healthcare Advanced Directives: The Patient's Right to Decide & The CHC Policy

Community Health Centers (CHC), Inc. will utilize a web camera to capture the image of its patients (and parent/guardian if a pediatric patient) in order to protect their identity, private health information and ensure accurate clinical care. The image is solely for identification purposes and the image will remain within the patient's electronic health record.

As a Federally Qualified Health Center, CHC, Inc. is covered by the Federal Tort Claims Act.

CONSENT TO TREAT & INFORMATION RELEASE

1. I voluntarily hereby consent to CHC, Inc. to provide evaluation, treatment, and therapy as deemed necessary to (name of patient) _____, including obtaining external prescription information. I authorize CHC, Inc. to release appropriate information concerning immunizations to schools for admittance as required by law and to the following: Social Security, the Centers for Medicare and Medicaid or its intermediaries (Medicaid/Medicare), or any other insurance compensation carrier for billing purposes.
2. I understand that in most cases it is mandatory to notify CHC, Inc. of any other party who may be responsible for paying for the patient above.
3. I authorize CHC, Inc. to release to my insurance carrier and its agents any information concerning health care, advice, treatment, supplies provided or supplies needed to determine these benefits or the benefits payable for related services.
4. I authorize the provider to make X-rays, study models, photographs or any other diagnostic aids deemed appropriate to complete a thorough diagnosis of the patient's needs. I also understand that all X-rays and diagnostic aids are the property of CHC, Inc. and that requested copies will be made available for a reasonable fee as allowed by law.
5. I further authorize the provider to choose and employ assistance as deemed appropriate. I also understand that the use of local anesthetic agents embodies a potential risk.
6. I understand that I may receive messages from CHC via telephone, text, and email. If you would like to opt out at any time, please contact a CHC team member. Standard text and data rates may apply.
7. The above information is true and I promise to notify CHC, Inc. of any changes in my medical history as soon as they occur.

Print Name of Consenting Person | Signature of Consenting Person | Date

Relationship to Patient is:

☐ Patient ☐ Parent ☐ Legal Guardian ☐ Authorized Person

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Patient Information Release Consent

I acknowledge that I have received a copy of Community Health Centers, Inc Notice of Privacy Practices. This notice describes how Community Health Centers, Inc. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

There are times when Community Health Centers (CHC), Inc. will need to contact you or when you may wish to allow family members and friends to have access to information concerning your medical care. Other than as allowed by federal law, **we will not release any information to any person except as authorized below by you.**

Please indicate by option number, your approved authorization for each individual listed below on this form.

1. Appointments (dates, location, times, provider, reason)
2. Treatment (prescriptions, medication refills, diagnosis, procedures, etc.)
3. Test and procedure results
4. Billing and payment information
5. All of the above

Name of Authorized Person	Option Number	Phone Number	Relationship
Name of Authorized Person	Option Number	Phone Number	Relationship
Name of Authorized Person	Option Number	Phone Number	Relationship
Name of Authorized Person	Option Number	Phone Number	Relationship

I understand that this consent is valid unless revoked by me and that I may revoke this authorization at any time.

Name of Patient (Type/Print) Date of Birth

Name of Consenting Person (Type/Print) Date

_____
Signature of Consenting Person

Relationship to Patient is:

☐ Patient ☐ Legal Guardian

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Designation of Health Care Surrogate for a Minor

I/We, _____|_____,
the [ ] natural guardian(s) as defined in s. 744.301(1), Florida Statutes; [ ] legal custodian(s); [ ] legal guardian(s) of the following minor:

_____
Name of Child Date of Birth

pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s), in the event that I/we am/are not able or reasonably available to provide consent for medical treatment and surgical and diagnostic procedures:

_____
Name Address, Zip Code Telephone

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/we designate the following person as my/our alternate health care surrogate for a minor:

_____
Name Address, Zip Code Telephone

I /We, authorize and request Community Health Centers, Inc. to follow the instructions of my/our surrogate or alternate surrogate, as the case may be, at any time and under any circumstances whatsoever, with regard to medical treatment which may include prescribing medicinal drugs and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility for medical or dental treatment. As these individuals will be acting on my behalf, I also agree to hold Community Health Centers, Inc. harmless (will not pursue legal action) for decisions which have been made by the named individuals regarding my child's health care. I understand I can revoke this consent at any time.

Stepparents, grandparents, adult brother or sister, and adult aunt or uncle can bring and consent to the treatment of a minor without authorization from the parent or legal guardian/custodian. Initialing below will prohibit these individuals from bringing the minor and consenting for treatment unless they are listed above or the minor's parent, legal guardian/custodian has been contacted and gives verbal authorization. To authorize only those named above to bring the minor and consent for treatment, INITIAL HERE: _____

I/We will notify and send a copy of this document to the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

_____ _____
Name Name

_____ _____
Signed Date

_____ _____
Signed Date

_____ _____
Witness 1 Witness 2

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Income Levels - Sliding Discount Program

See if you qualify for a discount in your healthcare fees!

You may qualify for discounted services even if you have Health Insurance – discount would be applied to insurance co-insurance and deductibles.

1: Find your family size in the left column; follow that row to your amount of annual total family income.
2: Circle that column.
3: A Customer Service Associate will let you know if you qualify for a discount.

Federal Schedule of Income (updated annually)

Family Size	Slide A From To	Slide B From To	Slide C From To	Slide D From To	Slide E From To	Slide F From To
1	$0 - $15,060	$15,061 - $18,825	$18,826 - $22,590	$22,591 - $26,355	$26,356 - $30,120	$30,121 & over
2	$0 - $20,440	$20,441 - $25,550	$25,551 - $30,660	$30,661 - $35,770	$35,771 - $40,880	$40,881 & over
3	$0 - $25,820	$25,821 - $32,275	$32,276 - $38,730	$38,731 - $45,185	$45,186 - $51,640	$51,641 & over
4	$0 - $31,200	$31,201 - $39,000	$39,001 - $46,800	$46,801 - $54,600	$54,601 - $62,400	$62,401 & over
5	$0 - $36,580	$36,581 - $45,725	$45,726 - $54,870	$54,871 - $64,015	$64,016 - $73,160	$73,161 & over
6	$0 - $41,960	$41,961 - $52,450	$52,451 - $62,941	$62,942 - $73,430	$73,431 - $83,920	$83,921 & over
7	$0 - $47,340	$47,341 - $59,175	$59,176 - $71,010	$71,011 - $82,845	$82,846 - $94,680	$94,681 & over
8	$0 - $52,720	$52,721 - $65,900	$65,901 - $79,080	$79,081 - $92,260	$92,261 - $105,440	$105,441 & over
Maximum Income as a % of Poverty	0-100%	101%-125%	126%-150%	151%-175%	176% 200%	>200%
Discount	Nominal Fee	80%	60%	40%	20%	0%
Nominal fee						
Medical	**$20 (additional fees apply for procedures, GYN surgery, OB deliveries)**					
Dental	**$25 (additional fees apply for dental labs, supplies)**					
Optometry	**$40 (additional fees apply for frames, lenses, tints)**					

For family units of more than 8 members, add $5,380 for each additional member.

☐ I am providing my income details; however, I am declining the option to apply for Community Health Centers, Inc. Medical, Dental and Optometry Sliding Fee Scale Program. (By Declining, I am accepting financial responsibility for the entire bill, including any fees that are not covered by my insurance plan and I agree to pay any balance in full)

☐ I am providing my income details and I would also like to apply for Community Health Centers, Inc. Medical, Dental and Optometry Sliding Fee Scale program. (You will be required to complete a Sliding Scale Application and provide proof of the above stated income, proof of residency and photo identification)

☐ I am declining your request for income details. (By declining to provide income details, I am also declining the option to apply for Community Health Centers, Inc. Medical, Dental and Optometry Sliding Fee Scale program, furthermore, I am accepting financial responsibility for the entire bill, including any fees that are not covered by my insurance plan and I agree to pay any balance in full)

_____ _____
Patient Name **Date of Birth**

_____ _____
Patient Signature **Date**

_____ _____
Staff Signature **Date**

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Income Attestation - Self Declaration

Testimonio DE Ingreso – Autodeclaracion
Atèstasyon Revni - Deklarasyon Pèsonèl

I, _____, do hereby declare the following annual income: $_____.I understand that by declaring the above income, I may be granted a three (3) Month period of eligibility on the Community Health Centers, Inc. sliding fee scale program. This eligibility will be based on the income stated above. I understand that after this three (3) Month eligibility period expires I will be required to provide documentation of income (or lack thereof) in order to maintain the previously determined status. Failure to produce any such documentation will result in a designation of Full Fee status. (Examples of such documentation include, but are not limited to, pay stubs, W-2's, Medicaid Denial, food stamps documentation, etc.). I understand that I may only self-declare my income one time every three (3) years at Community Health Centers, Inc.

Yo, _____, por la presente declaro el siguiente ingreso anual: $_____. Entiendo que al declarar el ingreso mencionado, se me puede conceder un período de tres (3) meses de elegibilidad en el programa de la escala de descuentos de Community Health Centers, Inc. Esta elegibilidad se basará de acuerdo a estos ingresos. Entiendo que después de que se venza este período de tres (3) meses de elegibilidad se me requiere proveer documentación de ingreso (o falta de ella) con el fin de mantener el status determinado previamente. Falta de dicha documentación resultará en el Pago Completo por los servicios. (Ejemplos de documentación incluye, pero no se limita a, talonarios de pago, formularios W-2 (impuestos), carta de negación de Medicaid, documentación de cupones de alimentos, etc.) Entiendo que sólo puedo declarar mis ingresos una vez cada tres (3) años en los centros de Community Health Centers, Inc.

Mwen, deklare pa mwayen sa a revni anyèl ki annapre a: $_. Mwen konprann ke lè mwen deklare revni ki mansyone pi wo a, Mwen kapab benefisye de yon peryòd de twa (3) mwa kote m ka kalifye pou pwogram tarif degresif nan Community Health Centers, Inc. la. Kalifikasyon sa a pral baze sou revni ki endike pi wo a. Mwen konprann ke apre twa (3) mwa peryòd m kalifye a ekspire mwen pral oblije bay dokiman sou revni (oswa si m pa te fè sa) yon fason pou m ka kenbe estati m te genyen anvan an. Si w pa bay youn nan dokiman sa yo, sa pral lakòz deziyasyon yon estati Frè konplè. (Egzanp dokiman sa yo genyen ladan yo, men se pa sa sèlman, souch chèk, W-2 a, Refi Medicaid, dokiman koupon pou manje, elatriye). Mwen konprann ke mwen ka sèlman deklare revni pou pwòp tèt pa m yon sèl fwa chak twa (3) zan nan Community Health Centers, Inc.

By signing below, I agree with the above requirements and expectations.
Al firmar, estoy de acuerdo con los requisitos anteriores y las expectativas.
Lè m siyen anba a, mwen dakò ak egzijans ansanm ak atant ki mansyone pi wo yo.

Name of Patient *Nombre del Paciente* *Non Pasyan an*	**Patient/Praent/Guardian Signature** *Firma del Paciente/Padre / Tutor Legal* *Non Siyati ak dat Pasyan / Paran / Gadyen*	**Date** *Fecha* *Dat*
Name of Witness *Nombre del Testigo* *Non Temwen an*	**Witness Signature** *Firma del Testigo* *Siyati Temwen*	**Date** *Fecha* *Dat*