SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

AUTHORIZATIONS FOR TREATMENT, CALL AND TEXT COMMUNICATIONS, PROHIBITED ITEMS ON PREMISES, AND ASSIGNMENT OF BENEFITS

OUTPATIENT AUTHORIZATION FOR TREATMENT

I consent to treatment as a SEARHC patient, including receiving evaluation, diagnostic, and therapeutic care recommended by my physician or other healthcare provider. I understand that I will be separately informed by my physician or other healthcare provider about my proposed treatment, the risks inherent in the proposed treatment, and alternatives to the proposed treatment. I understand I have the right to ask questions about the proposed treatment, the right to make decisions concerning my plan of care, the right to choose to refuse medical care, and the right to obtain information about my health needs and treatment from my physician or other healthcare provider.

TELEHEALTH AND ELECTRONIC VISITS (eVisits) INFORMED CONSENT

1. I understand that a variety of alternative methods of medical care may be available to me, including Telehealth and eVisits, and that I may choose one of these if it is appropriate for my situation and after consultation with my healthcare provider.

    a. Telehealth means the use of communication technologies to meet with a healthcare provider in real time. This can be done by meeting with a healthcare provider using real time audio technologies or using real time audio-video technologies.

    b. eVisits mean communicating with a healthcare provider through electronic methods such as email, text message, and the SEARHC patient portal (asking a medical question, filling out a health questionnaire, requesting a prescription refill, etc.).

2. I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telemedicine and eVisits.

3. I understand that I have the right to withhold or withdraw my consent to the use of Telemedicine and eVisits in the course of my care at any time, without affecting my right to future care or treatment.

4. I understand that Telemedicine and eVisits may involve electronic communication of my personal medical information to other medical practitioners within SEARHC or outside of SEARHC at my request.

5. I understand that I may expect anticipated benefits from the use of Telemedicine and eVisits in my care, but that no results can be guaranteed or assured.

6. For all Telehealth appointments and encounters with SEARHC healthcare providers, I attest that I will be physically located in the State of Alaska.

7. I understand that Telemedicine and eVisits visits will be billed in the usual manner to my insurance and other responsible third parties, if applicable.

I have read and understand the information provided above regarding Telemedicine and eVisits. By checking the box in this section, I give my informed consent for the use of Telemedicine and eVisits in my medical care.

COMMUNICATION BY PHONE AND UNENCRYPTED TEXT MESSAGE

I consent to receive calls and unencrypted text messages from SEARHC relating to my healthcare, medical services, and any related financial obligations. I understand there are risks with the use of unencrypted text messaging. For example, text messages can be intercepted, changed, forwarded, stored, or used without my permission. I understand that SEARHC is not responsible for the security and confidentiality of a text message once it leaves their control, including what happens to the information both in transit and upon arrival, what I do with the message once I receive it, and who else sees the information. I understand my cellular service provider may charge a fee for 1) making and receiving calls and 2) transmitting and receiving text messages and that I am fully responsible for those charges. I understand that I have the right to opt out of receiving unencrypted text messages and calls from SEARHC at any time. It is my responsibility to contact SEARHC if I wish to opt out of receiving unencrypted text messages and calls.

No mobile information will be shared with third parties/affiliates for marketing/promotional purposes.

I have read and understand the information provided above regarding calls and text messages. By checking the box in this section, I give my informed consent for the use of calls and text messages in my medical care.

PROHIBITED ITEMS ON SEARHC PREMISES

SEARHC strives to provide a safe atmosphere for its patients, visitors, and employees. Contraband, weapons, alcohol, illegal drugs, and drug paraphernalia are strictly prohibited and will be confiscated. Individuals who bring, or who are suspected of bringing, prohibited items into a SEARHC facility may be asked to leave and trespassed.

ASSIGNMENT OF INSURANCE AND OTHER BENEFITS

I assign to SEARHC the right to collect payments from insurance or any other responsible third parties for services provided to me by SEARHC, and specifically authorize any third-party insurance benefits to be paid directly to SEARHC. I understand I may be financially responsible to pay for any services not covered by SEARHC and not paid by insurance or other responsible third parties and agree to pay SEARHC for those services.

Alaska Native/American Indian beneficiaries (with documented eligibility) are not financially responsible for services covered by SEARHC. Not all services are covered by SEARHC. Beneficiaries without third-party insurance may be financially responsible for services not covered by SEARHC. These include eyeglasses, hearing aids, some dental services, and medications not included in the SEARHC Medication Benefits Package.

SIGNATURE

This authorization will be valid for one (1) year from the date of signature unless revoked earlier by the patient or their Legal Decision Maker.

If the patient is a minor, or patient has an Agent, Power of Attorney, Surrogate, or Legal Guardian (Legal Decision Maker), then I, as the person with legal decision-making authority, authorize the above consents for this patient.

Patient Name (Print): _____

Patient / Parent / Legal Decision Maker Signature: _____

Date: _____

If Patient is a minor or has a Legal Decision Maker:

Name of Parent / Legal Decision Maker (Print): _____

Relationship: _____

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The following is needed to meet Federal funding reporting regulations for SEARHC:

1. Ethnicity
   - □ Hispanic or Latino
   - □ Not Hispanic or Latino
   - □ Unknown by patient
   - □ Decline to Answer

2. Race
   - □ American Indian or Alaska Native
   - □ Asian
   - □ Black or African American
   - □ Hispanic, Black
   - □ Hispanic, White
   - □ White
   - □ Native Hawaiian or Other Pacific Islander
   - □ Unknown by Patient
   - □ Decline to Answer

3. Primary Language_____ Interpreter required? □ Yes □ No

4. Preferred language _____

5. Are you a migrant worker? □ Yes □ No

6. Are you homeless? □ Yes □ No
   If yes: □ Homeless shelter □ Transitional □ Doubling up □ Street □ Other □ Unknown

7. Do you have internet access: □ Yes □ No
   If yes:
   - □ Home
   - □ Work
   - □ School
   - □ Healthcare Facility
   - □ Library
   - □ Tribe/Community Center
   - □ Mobile Device

8. Email address: _____

9, I give permission for SEARHC to email generic health information: □ Yes □ No

10. Preferred method for receiving appointment reminders (select only one): □ Phone □ Email □ Mail

11. Number of persons in household _____

12. Estimated Household Income_____ □ Week □ Bi-Weekly □ Monthly □ Yearly

13. Do you need help to □ See □ Hear

14. Are you a Veteran? □ Yes □ No