JEAN B PURVIS COMMUNITY HEALTH CENTER OF BUTLER COUNTY

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PATIENT STATEMENT OF UNDERSTANDING

PLEASE REVIEW THE FOLLOWING CAREFULLY TO UNDERSTAND CHC SERVICES.

- **I understand** that **ALL** services provided by the Community Health Center (CHC) are free of charge.
- **I understand** that services provided by CHC may include primary medical care, basic dental care, health & wellness programs, behavioral health, prescription assistance, case management and patient education.
- **I understand** that CHC does not duplicate available services in the community.
- **I understand** that CHC does not provide emergency care. If I believe my concern is urgent or life threatening, I will seek services at the nearest emergency room at my own expense.
- **I understand** that at times, I may be referred to another provider or specialist. Some providers or specialist may be able to provide services at a free or reduced cost, however, any expenses incurred through other providers and/or specialist are my responsibility. It is up to me to make financial arrangements/payments with the other provider and/or specialist directly.
- **I understand** that I am required to provide the following documentation: photo ID, proof of household income and a copy of my most recent tax return. Income documentation and tax return will be used to determine my eligibility for services at CHC and required on a yearly basis to continue services at CHC. I am required to update CHC with any changes to my income and/or status of medical insurance.
- **I understand** that I will apply for available health insurance or Medical Assistance and I will provide proof of acceptance or denial to CHC.
- **I understand** that CHC will work to the best of their ability to provide medications at no cost to me. However, I am ultimately responsible for the cost of my medications.
- **I understand** that CHC may obtain medications through Patient Assistance Programs (PAP) sponsored by major pharmaceutical companies. If I meet edibility requirements for PAP, **I give my permission to the CHC Medical Director or designee to sign my name on the medication order form.** My name will only be signed on medication orders specifically for me as prescribed by my physician.
- **I understand** that I will give CHC at least 24 hours' notice to cancel any appointment – **exception: Dental appointments require 48 hours' notice.** If I miss up to three (3) appointments at CHC without notifying the clinic in advance, CHC reserves the right to discharge me as a patient.
- **I understand** that I will keep all specialist referral appointments. If I do not directly call the specialist's office to cancel/reschedule a single appointment, **at least 24 hours in advance**, I will be denied future specialist referrals.
- **I understand** that CHC staff and volunteers are committed to treating patients with dignity and respect and that I am expected to respect the staff and volunteers who provide my healthcare.
- **I understand** that CHC strives to provide an environment that is free of sexual harassment, and that any conduct, verbal, non-verbal or physical by a patient that is deemed by CHC to unreasonably interfere with the work performance of the clinic staff/volunteers; or which creates an intimidating, hostile or offensive work environment; or which is inappropriate because it is of a suggestive, argumentative or sexually inappropriate nature shall result in the termination of further services.
- **I understand** that I am responsible for my own care. It is my responsibility to follow the recommendations, treatments and prescribed medication(s) offered by CHC.

CONSENT TO TREATMENT

I hereby request and consent to the rendering of health care by the Community Health Center. I understand that this clinic is staffed by a health care team which may include physicians, dentists, nurse practitioners, nurses, technicians and other volunteers. I freely accept care from this health care team and acknowledge the establishment of the provider/patient relationship. I further understand that this health care team will provide information and/or care; however, I maintain the right to make all decisions regarding my care. This consent is to remain in effect until it is revoked by me in writing.