TIBURCIO VASQUEZ Health Center

Consent for Treatment, Payment & Notification

Patient Label

I understand that I have the right to see my healthcare provider in-person, face-to-face visit, and/or by telehealth services. I hereby consent to the following:

I. **Treatment**: I give permission for Tiburcio Vasquez Health Center Inc. (TVHC) healthcare provider to give me medical treatment. Treatments may include but are not limited to the following: medical, dental, specialty services, lab tests, immunizations, medication, education, and/or other treatments considered necessary by my healthcare provider. I understand that my provider is available to explain the treatment and I have the right to decline any treatment or procedure.

II. **Telehealth Services**:

A. I understand that I have the option to decline telehealth services at any time without any consequences. I am aware that I may still pursue face-to-face consultation. I understand I may withdraw my consent at any time without affecting my ability to access future services.

B. I am aware that the healthcare provider or specialist will provide the consultation over video and/or phone.

C. I understand that I need to make sure that my computer or the device I will use to access telehealth service(s) is secure.

D. I will be told if any additional personnel will be present other than myself and the provider. I will give my verbal consent before entry of additional personnel.

E. I understand the telehealth process may relay audio and video digital images, test results, or details of my medical record with TVHC providers.

F. I am aware that there are limitations to telehealth and that it does not substitute the need for me to see a provider or specialist in person.

G. The provider will keep a record of the telehealth visit in my medical record.

III. **Payment**: I agree to pay for services provided to me by TVHC. I permit TVHC to bill my insurance for the services I receive. I understand that TVHC may have to send my medical information to my insurance company. I also agree to provide, in writing, information that may be needed for consistent care at other health facilities operated by TVHC. I am aware that I may be responsible for any fees not covered by my insurance. I understand that fees will be determined by TVHC policies and regulations.

IV. **Notification:** I authorize TVHC to notify me via phone or text message for appointment reminders and information about my healthcare treatment as well as other TVHC services. I understand that standard message and data rates may apply from my cell phone plan. I am aware that I may stop receiving text messages at any time by replying "STOP." By replying "STOP," I understand that I will no longer receive text messages from TVHC.

V. **Acknowledgments:**

☐I understand that this consent/authorization will remain in effect until I request removal in writing.

☐I have received a copy of TVHC's Notice of Privacy Practice and Patient Rights and Responsibilities.

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 communicated.

_____	_____	_____/_____/_____
Translator Signature	Print Name	Date