All-Inclusive Community Health Center
1311 N. San Fernando Blvd, Burbank, CA 91504
17114 Devonshire St, Ste 200, Northridge, CA 91325
3920 Eagle Rock Blvd, Ste A, Los Angeles, CA 90064
Tel: 818-843-9900 Fax: 818-843-9901 E-mail:info@aichc.org

TREATMENT AGREEMENT

1. CONSENT TO TREATMENT

I, ____, hereby voluntarily request, consent to and authorize my attending physician, his associates, assistants, behavior health clinician or other practitioners under his orders to attend to me at **All-Inclusive Community Health Center (AICHC)** and to provide medical and surgical treatment, including, but not limited to, diagnostic procedures, x-rays, referrals and administration of medications, as is deemed necessary and advisable. AICHC tests all patients for HIV unless they opt out from testing. I consent to HIV testing based on a verbal request and oral agreement. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments and examination. I understand that my rights to confidentiality are limited by the following circumstances which we are mandated to report: a danger to selves or others, cases of abuse and cases that may have a negative effect on others.

❑ I opt out of routine testing for HIV and Syphilis.

______________________________	____________	______________________________
Signature of witness	Date	Signature of patient or legal representative

2. RELEASE OF INFORMATION

I hereby authorize AICHC to release information, in written form, by phone, facsimile machine or other types of electronic communication, contained in the patient's medical records for the purposes of "**treatment payment and healthcare operations**" to:

a. Any third party payer, employer, or insurance company (including but not limited to Medicare, Medicaid, maternal and infant health. Blue Cross/Blue Shield, commercial health insurers, automobile no-fault insurers, worker's disability compensation insurers and health maintenance organizations) which are responsible in whole or in part for paying the patient's medical bill that AICHC may receive payment or reimbursement for the services provided to the patient.
b. Any health care facility, physician, durable medical equipment supplier, or other ancillary services provider to which the patient is referred or transferred or to which referral transfer is contemplated for the purpose of facilitating continuity of the patient's health care.
c. Any independent auditors hired or retained by any and all third party payers, private health insurers and or any employer providing health insurance benefits to the patient applicable to the patient's hospitalization for the purpose of enabling these independent auditors to analyze charges made for services rendered to the patient.
d. The release authorization shall be effective only so long as is necessary to accomplish the purpose for which it is given. I understand that I may revoke this consent at any time (unless otherwise restricted by law) by written request unless AICHC has already released information in reliance upon it.
e. If psychiatric records, HIV/AIDS information, substance abuse information, tuberculosis information, genetic information and/or sexually transmitted disease information is included in these records, initial next to the appropriate line below in order to **specifically authorize and include** such records in this release:

____HIV/AIPS Related Information	____Mental Health and Psychotherapy Information
____Genetic Information	____Sexually Transmitted Disease Information
____Drug and Alcohol information	____Tuberculosis Information

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NOTE: If this section (2e) is left blank, authorization to release psychiatric records, HIV/AIDS records, substance abuse records, mental health records, STD records and TB records will be presumed to be DENIED. I understand that no Alcohol and Drug abuse information and HIV/AIDS related information or psychotherapy notes may be disclosed by my signing this authorization and that a separate authorization would be required for the release of psychotherapy notes, alcohol and/or drug treatment information or HIV/AIDS related information.

3. ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign, transfer and set over unto AICHC, as its interest may appear all benefits now due or becoming due to me by virtue of the present treatment.

4. AGREEMENT TO PAY FOR SERVICES.

I understand that I am liable and responsible for any health insurance deductibles and coinsurance portions of my bill. I also understand that I am responsible for paying for all services to be rendered to the patient whether signing as agent or as patient

The undersigned certifies that (s)he has read the foregoing or that it has been read to him/her, and that (s)he understand the same and consents thereto, and that (s)he is the patient or duly authorized representative or agent of the patient to sign this form and consent thereto.

I further understand that my treatment may require more than one occasion of service, therefore; this consent shall carry full force and effect from the date of signature until I am discharged from further outpatient treatment

As an outpatient, I understand that treatment may be rendered at AICHC. Its outpatient facility or one of its outpatient satellites.

I further understand and acknowledge that an HIV test may be performed upon myself, and in cases of birth, my child/children, without the written consent required under circumstances that a health professional, other health facility employee or emergency first responder (as defined in Act 419 of 1994) sustains a percutaneous mucous membrane, or open wound exposure to my, or In cases of birth, my child/children's blood or other body fluids.

______________________________	____________________________________	____________________________	____________________
Signature of patient or personal representative	Name of patient or personal representative	Relationship to the patient (if not self)	Date

______________________________	____	____________________
Signature of witness	Name of witness	Date

If patient is unable to sign or is a minor, complete the following;
Patient is (a minor _____ years of age or is) unable to sign because ____

Patient's Name: ____ **Date of Birth:** ____