CHA Cambridge Health Alliance

Ambulatory Services Consent for Treatment - English

(patient label here)

My Agreements (Consent for Treatment)
Ambulatory Services

Welcome to Cambridge Health Alliance! By state law, we need your permission (consent) before we can give you care. Ask about anything you don't understand. We are here to help you.

When you feel you understand and agree, please sign this paper.

1. Some of the people who treat me may be students or doctors in training, however there is always a fully-trained person in charge of my care. I have the right to say no to care by any doctor, nurse or other health caregiver.

2. If it is not an emergency, I can say no to any caregiver and any treatment. But if I am having a medical emergency, staff may have to treat me before I give permission.

3. I understand that my provider will submit prescriptions electronically to my pharmacy. My provider will be able to view prescriptions supplied to me by pharmacies, including medications prescribed by other providers. This process helps prevent mistakes and helps my provider give me the best and safest care possible.

4. I will have to pay the bills for anything my insurance doesn't cover (this includes co-pays and deductibles). Insurance payments will go to you (Cambridge Health Alliance and Cambridge Health Alliance Physicians Organization), not to me. This includes payments from Medicare.

5. I can find more detail on how you use and share my medical information in the Notice of Privacy Practices, which I have received. I understand that I can request a restriction on how my medical information is used or shared, but that you may not be able to fulfill my request.

6. I understand you treat my medical information as confidential as defined in federal and state privacy laws. These laws allow you to share my medical information, as necessary, inside AND outside this organization: (1) to treat me, (2) to get paid for my care, (3) to help you improve how you provide healthcare.

I understand and agree. I give my consent for care. I have received a copy of the Notice of Privacy Practices. I understand I may take back this consent at any time in writing, but that I cannot take back my consent for actions that have already been taken.

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Signature of patient or person authorized to sign for patient   Date/Time

Interpreter ID:____
☐ Phone ☐ Video ☐ In person

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Interpreter Signature (if present)   Date/Time