Benton County | Community Health Centers of Benton & Linn Counties

Benton Health Services

Benton County Health Department and
Benton Community Health Center

Name _____

Client # _____ DOB _____

Client Consent and Acceptance of Clinic Policies

Benton Health Services (BHS) provide information that all clients need to know in order to have the best experience possible. Please read the information provided to better understand our policies and your rights and responsibilities as a client. Services are provided on a voluntary basis. Clients cannot be coerced to accept services or any particular method of treatment. Clients can chose to get care from any of our programs that they choose or that will benefit their overall health and wellness needs.

Clients Right and Responsibilities

Clients of BHS have certain rights and responsibilities that are explained in the "Client Rights and Responsibilities" brochure. You are responsible for complying with these as a client of BHS. There is also a brochure that describes the "Client Complaint and Grievance Process". Please contact us with any questions you may have.

Finance Policy and Billing Consent

All clients are responsible to pay in full for all services

Clients with insurance: Please bring your insurance card each time you receive services. You are responsible to pay your co-pay prior to service. You are also responsible for services or amounts not covered by your insurance. If there is a concern about paying for this portion, you may ask to apply for the Sliding Fee Program. You may also choose to not bill your insurance for a specific visit and you will be responsible for the full cost of undiscounted services provided to you in that visit.

Insurance Assignment: By signing below, I authorize any payment of medical benefits from my insurance to be paid directly to BHS. BHS cannot accept responsibility for collecting my insurance claims or negotiating a settlement on a disputed claim. Finance charges may be assessed against any accounts, including those that will be paid ultimately by insurance benefits. BHS fees may not be the same as those reimbursed under Medicare, Medicaid, TRICARE, VA, etc.

Clients without insurance: Clients are expected to pay at least the minimum fee prior to service. Any additional balance will be collected during the check-out process. If there is a concern about paying the full balance at check-out, you may ask to apply for the Sliding Fee Program at check-in or talk with our Business Office staff to set up a payment plan.

Family Planning Clients: Clients are not required to pay any minimum fees. Clients may not be required to pay insurance co-pays. Family planning services will be discounted according to the sliding fee scale based on family size and income. If there is a concern about paying for the services at check-out, arrangements may be made to talk with our Business Office staff to set up a payment plan.

Public Health Clients: Clients may not be required to pay the minimum fee. Programs that do not have client charges associated with services will be excluded from all self payment requirements.

A fee of $12.50 will be charged for all checks returned for non-sufficient funds (NSF) or written on a closed account.

BHS will refund credit balances of less than $5.00 by request only. If you receive a refund check in the amount of $20.00 or less and do not cash it within 90 days, you will forfeit the amount as a service charge (OAR 98.311).

Laboratory Information:

In clinic tests:

- Included in the Sliding Fee discount calculation
- Courtesy billed to insurance companies by BHS

Outside laboratory tests

- Excluded from the Sliding Fee discount calculation (except for Family Planning clients)
- Courtesy billed to insurance companies by outside laboratory
- Clients without insurance billed by BHS

Scheduling Guidelines:

We value your time and well being. We have set our time aside to serve your health needs. Please value our time by keeping your appointments. If you are unable to keep your appointment, please notify us 24 hours in advance. Clients who miss appointments without providing this advanced notification may be denied the privilege of scheduling appointments in the future.

Informed Consent for Telehealth Consultations

Benton County Health Services (BCHS) which includes Benton County Health Department and the Health Centers of Benton and Linn Counties are offering virtual health or telehealth to our clients through telephone, video, and electronic message visits.

It is important that you understand and agree to the below Telehealth terms.

- The service provider will be at a different location from me. I will connect to the virtual visit from home or someplace other than the provider's office.
- I understand that I need to be in the state of Oregon to receive Telehealth Services.
- I will be informed if any additional people will be present other than myself, individuals accompanying me, and the provider or specialist. I will give my verbal permission prior to the entry of the additional people.
- It is my responsibility to prevent others from overseeing and/or overhearing my side of the details of my virtual visit.
- The provider will keep a record of the consultation in my medical record.
- Release of Information: BCHS and/or providers who provide professional services to me are authorized to furnish medical information from my medical record to the referring physician, if any, and to any insurance company or third party payer for the purpose of obtaining payment on my account. BCHS is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.

- I voluntarily consent to health care services provided by my provider(s) or a designee, which may include diagnostic tests, medications, and examinations.

- I understand that if I do not choose to participate in a telehealth visit, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

- I understand that as with any technology, telehealth does have its limitations. There is no guarantee that this telehealth visit will eliminate the need for me to see a provider in person.

Patient Acceptance and Authorization

By reading and signing this form I accept my rights and responsibilities as a client and consent to the treatment and services provided by Benton Health Services. In addition, by signing this form, I certify that I have not withheld insurance coverage information existent at the time of this service and that no other insurance coverage exists beyond that which I have provided. I accept full responsibility for all charges whether or not they are covered by insurance. I authorized BHS to release all information necessary to my insurance company to make payment. I have read and understand the above information and hereby give authorization for payment of insurance benefits to be made directly to BHS for services rendered.

As a client of Benton Health Services I agree to actively engage in my treatment and clinical education as a participating member of Benton Health Service's Patient Centered Primary Care Home and consider this my medical home.

_____ _____

Patient's Signature/Authorized Representative Date

_____

Printed Name (Required)

_____

Minor's Signature (if applicable)

_____

Witness Signature (Required for Minor Above)