Consent:

To provide treatment, bill your insurance, or release information required by your insurance carrier, we must receive your consent by initialing the areas indicated and/or by providing your signature below.

Release of Information: I understand this information may include drug and alcohol, mental health, HIV/AIDS test results and/or genetic testing, and this authorization is valid unless cancelled by me in writing.

I, _____ (__ Self; __Parent; __Legal Guardian), give my permission for:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

____ To receive information from HealthLinc relating to any part of my medical/dental care (or that of my dependent listed above).
____ To reschedule appointments on my behalf (or for my dependent listed above).
____ To access my protected health information via HealthLinc patient portal.
____ HealthLinc to leave a voicemail with test results.

Consent of Treatment:
I consent to necessary care by my provider and agree to comply with the treatment plan. If I do not comply with the treatment plan, HealthLinc may choose not to provide further care.

_____ (**initials)**

Statement of Agreement:
I have been advised of my rights and obligations related to HealthLinc's Policies and Procedures.

_____ **(initials)**

Notice of Privacy Practices
HealthLinc is committed to protecting your personal health information in compliance with the law. A copy of the Notice of Privacy Practices and any Addendum are available upon request.
I hereby acknowledge that I have received/been offered a copy of the Notice of Privacy Practices and any Addendum.

Signed: _____**Date**: _____

Parent/Patient's Representative (if a dependent) _____Date: _____

Relationship: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency prevented us from obtaining acknowledgment
- Other (specify)_____ Staff Initials: _____

No Show Procedure: Failure to call for canceling or rescheduling an appointment 24 hours in advance will result in a no show. Three (3) no shows in a six (6) month period will result in HealthLinc following the below procedure:

Medical/Optical:

- 1st no show – Phone call regarding our no-show policy
- 2nd no show – Warning letter
- 3rd no show - Will be placed on stand-by-only appointment status

Dental:

- 1st no show – Phone call regarding our no-show policy
- 2nd no show – Warning letter
- 3rd no show – No appointments for 6 months

Note: if you arrive 10 minutes after your scheduled appointment time, you will be seen at the dentist's discretion. In emergency situations, you will be seen on a "work-in" basis, and you will have to wait until the schedule allows. If you are given an emergency appointment and no show, you will not be given another emergency appointment and will have to wait until the regular schedule allows.

Signature: _____Date:_____