Southeastern Idaho Public Health

Declaration of Income & Universal Consent

I have read or had explained to me, and agree to the following forms:

- **Declaration of Income**
  - I hereby affirm that to the best of my knowledge and belief, this income statement is true and correct. I understand that based on my income I may be eligible to receive services at a discounted price.
  - If I am unable to pay for the discounted services that I receive in the full amount, I will not be penalized or denied services, but I may work with SIPH to set up a payment plan.
  - I also understand that Southeastern Idaho Public Health does accept donation amounts for the services that I receive today and that donations make it possible for SIPH to continue to provide services to the community.

- **Consent for Services**
  - By signing, I am giving consent to be seen today and receive services deemed necessary and appropriate by SIPH clinic staff.
  - For clients under 18, Idaho law now requires parental or guardian consent for most non-emergency healthcare services. If you have questions about what this means for your care, please speak with a staff member before signing.

- **Financial Policy**
  - I understand that there are fees for SIPH services. SIPH will bill most insurance plans, but if for any reason they do not pay, a bill will be sent to me.

- **Notice of Privacy Practices**
  - I acknowledge that I have been offered a copy of SIPH's *Notice of Privacy Practices*, which describes how my protected health information (PHI) may be used and disclosed for purposes of treatment, payment, and healthcare operations. I understand I have the right to review the notice, ask questions, and request a copy at any time. By signing below, I consent to SIPH's use and disclosure of my PHI as outlined in the notice.

The policies listed above are on display. If you would like a copy to take with you or have any questions, please feel free to ask one of our staff.

Consent for Services

I hereby request and authorize the clinic to provide health care services available and deemed necessary by the clinic staff. These services may include but are not limited to evaluation of my medical and family history, physical examination, laboratory tests *including Rapid HIV tests*, X-rays or photographs, medications or prescriptions, injections or immunizations, minor surgical procedures, prenatal counseling and family planning counseling services. If you are under the age of 18, you must have parent or legal guardian consent for any non-emergency medical services, including immunizations. Idaho law requires parental or guardian authorization for care provided to minors except in certain emergency situations or under a court order

I understand that no test is perfect and all tests may fail to detect a problem (false negative) or suggest a problem when none exists (false positive).

Since some medical conditions may affect my care, it is my responsibility to give as complete and accurate a medical history as possible. If new problems that may be related to my condition or care arise, I understand I should inform the clinic of this. I understand that SIPH does not provide all types of medical care, and I am responsible for obtaining care elsewhere for unrelated or specialty services not offered by the clinic.

I understand I have the right to decline any services offered, including lab tests, *Rapid HIV Testing* or other procedures, and that this will not affect my ability to receive other appropriate care.

I understand that if I receive a ThinPrep Pap test, my provider may request HPV testing based on clinical guidelines. I understand that I or my insurance will be billed directly by LabCorp for this test.

All services provided by SIPH are confidential. However, I understand that certain test results (such as for sexually transmitted infections or reportable diseases) must be disclosed to the Idaho Department of Health and Welfare, as required by state law.

If I am under 18 and disclose a history of sexual abuse, physical abuse, or neglect, I understand that SIPH is legally required to report this information to child protection authorities.

The undersigned has read, fully understands, and agrees to all of the above provisions and information in this document.

Printed Client Name _____

Client Signature _____ Date_____

Witness Signature _____ Date_____

Signature if other than patient _____ Date_____

Legal relationship to patient _____ Date_____

Southeastern Idaho Public Health

Financial Policy

Please read the SIPH Financial Policy carefully. Fees vary by service type and may depend on your income and insurance coverage. Circle and initial the type of services you are receiving, and sign at the bottom to indicate your understanding and agreement. If you have questions about fees, billing, or your eligibility for discounted services, please ask staff before signing

Family Planning/Title X & STD Services

The goal of our clinic is to provide you with high-quality health care at a reasonable cost. **SIPH is not a free clinic, but we offer reduced fees based on income for eligible clients**. Title X clients' fees are based on a sliding fee schedule in accordance with the annual Federal Poverty Levels (FPL). To determine your FPL. You must provide proof of income (such as a recent pay stub, W-2, or benefits letter) to determine your eligibility for discounted fees under the Title X sliding fee scale. If you do not bring proof to today's visit, you may be required to pay full fees at your next appointment unless documentation is provided. In order to continue to provide these services, prompt payment for services and supplies is greatly appreciated.

- No one will be denied services for an inability to pay.
- SIPH can bill all insurance carriers when clients provide necessary billing information and with your (the client's) approval.
- If a balance remains after the sliding fee scale is applied to clients above 101% of the Federal Poverty Level, the balance becomes your responsibility.
- If any amount is still owed for your clinic visit today, and you are unable to pay balance, please ask for payment arrangements.
- If you have an account balance, it does not affect your ability to continue receiving services.
    - If an account balance remains and if prior payment arrangements have not been fulfilled, SIPH will try to obtain the remaining balance by making a new arrangement with you or using a collection agency as a last resort. Clients who request confidentiality with SIPH will be exempted from the collection agency process.
- Cash, checks, and credit cards are accepted.
- We will not issue any refunds for less than $25.00. The balance will be applied to your account as a credit.
- All Family Planning/Title X clients can voluntarily donate any amount towards the continuation of the program.
- Insurance subscribers may receive an EOB (explanation of benefits).

Childhood Immunizations

- All childhood immunizations will be billed to your insurance company, if you have one.
    - Any balance not covered by your insurance provider is your responsibility to pay.

        - If needed, we can set up a payment plan that works for you.
- Note: If you are insured only by Tricare, and/or if your child's residency is not in Idaho, please talk with a SIPH representative for more information.

Adult Immunizations

- We will bill Medicaid or any insurance company for covered immunizations; otherwise, payment is required at the time of service.
    - Any co-pay or deductible is your responsibility to pay.
    - Any immunization that is not covered is your responsibility to pay.
    - If needed, we can set up a payment plan that works for you.
- We can provide a "super bill" for you to submit to any other insurance for reimbursement.
    - If you are unable to pay in full, please speak with staff about setting up a payment plan.

Adult Flu & Pneumonia Shots

- We will bill Medicare, Medicare/HMO, Medicaid, or all insurances; otherwise, payment is required at time of service.
    - Any co-pay or deductible is your responsibility to pay.
    - Medicare will only cover certain vaccines based on your eligibility and diagnosis. If Medicare does not pay, you are responsible for any balance.
    - If you are unable to pay in full, please speak with staff about setting up a payment plan.

Tuberculosis (TB)

- If you have a case of TB that has been diagnosed as Latent by a physician, we bill Medicaid or any insurance; otherwise, payment is required at time of service.
    - Any co-pay or deductible is your responsibility to pay.
    - Any balance not covered by your insurance company is your responsibility to pay.
    - Any associated costs, such as lab work, will be your responsibility to pay.
    - If you are unable to pay in full, please speak with staff about setting up a payment plan.

I have read the Financial Policy. I have been given an opportunity to have my questions answered regarding this policy. I understand and agree with this policy. I authorize the release of any medical information necessary to process my claims and understand that my insurance may be billed for services provided. I authorize payment of benefits directly to Southeastern Idaho Public Health. I understand that I am financially responsible for any charges not covered by my insurance or sliding fee adjustment.

_____ _____

Client Signature Date

Southeastern Idaho Public Health

Patient Bill of Rights

YOU HAVE THE RIGHT TO…

RESPECT

- Be spoken to with dignity and good manners, at all times
- Have your cultural, spiritual, and personal values honored when receiving health care
- Be called by your chosen name and preferred gender pronoun
- Know the names of staff caring for you
- Ask a staff member to be with you during your exam
- Receive care in an environment free from harassment or abuse

CONFIDENTIALITY

- Expect that your health records are kept private
- Expect that your health records are only shared with your written consent, unless required by law or health insurance
- Receive care in ways that ensure your privacy and safety
- Access your medical records and request copies as allowed by law
- Request corrections to your health records if you believe they are inaccurate
- Request a restriction on the use or disclosure of your protected health information, **where legally allowed**

QUALITY SERVICES

- Be offered a range of family planning services by qualified staff
- Get quality care no matter what your race, ethnicity, religion, sex, gender, sexual orientation, disability, marital status, number of pregnancies, and birth control choice are

VOLUNTARY PARTICIPATION

- Refuse any and all services without penalty
- Be included in decisions about your care

INFORMATION

- Get medically accurate information with no judgments
- Get clear information in your preferred language
- Be informed about your diagnosis and treatment options in terms you understand
- Receive written information when required by law or program policy

- Be informed about your clinic's policies and procedures, including costs for services and what your insurance will cover

STATE YOUR CONCERNS

- Ask questions about anything that concerns you or that you do not understand
- Have your complaints handled quickly and with respect
- Offer suggestions to improve services

This clinic supports your rights under HIPAA, state and federal law, and relevant public health program guidelines. If you have questions or feel your rights are not respected, please speak with a staff member or request our grievance policy.

Universal Consent Form

This form confirms your understanding and agreement to receive services and outlines how your health information may be used and shared. I have read and agree to the following forms:

- Declaration of Income and Universal Consent
- Consent for Services
- Financial Policy (if applicable)
- Title X Patient Bill of Right (if applicable)
- School Immunization Release Consent
- Notice of Private Practices (HIPAA)
    - You have the right to read our Privacy Practices before you decide whether to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.
    - Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
    - I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
    - I authorize SIPH to release immunization records for the named client/child to their primary or secondary school for the purpose of school enrollment or compliance with immunization requirements. I affirm under penalty of perjury under Idaho law that I am authorized to sign this release on behalf of the client/child.

_____ _____

Client Signature Signature if other than patient

_____ Legal relationship to patient: _____

Patient Full Name

_____

Current Date

.....For Staff Use Only.....

_____ _____

Staff/Witness Signature Printed Name

In the event the client *signature is not* obtained for any reason, staff should document and sign below:
The following good faith efforts were made to obtain acknowledgment:

_____

_____

However, acknowledgement was not obtained because:

_____

_____ _____

Staff/Witness Signature Printed Name

Telehealth Consent Form

This form provides consent for Southeastern Idaho Public Health (SIPH) to provide healthcare services via telehealth technologies, including phone or video communications.

What is Telehealth

Telehealth is the use of electronic communication to provide health care services when the patient and provider are in different physical locations. This may include:

- Phone consultations
- Video visits
- Secure messaging or follow-up instructions

Risks and Limitations

I understand that:

- Telehealth has limitations, including the inability to perform some physical exams.
- Technology failures (e.g., dropped calls, poor image/sound) can disrupt services.
- My provider will determine whether telehealth is appropriate for my care.
- Privacy risks exist when using electronic communication, though SIPH uses secure platforms when possible.

Confidentiality

- My health information shared through telehealth is protected by HIPAA, the same as with in-person care.
- Telehealth services will not be recorded without my explicit permission.

Consent

I understand the information above and agree to receive services via telehealth. I understand I can withdraw this consent at any time

Signature:

_____

_____ _____

Staff/Witness Signature Printed Name rev. 8.2025