HealthNet
Your Health. Our Passion.

Staff Use Only:

Account Number: _____

General Consent and Financial Agreement

Patient Name: _____ Date of Birth: _____

General Consent for Medical and Dental Treatment and Services

HealthNet providers and other staff may give me or my child health care, like exams, tests, and ways to improve my or my child's health. I know that HealthNet cannot promise health results or cures. I know that students in health care learn from HealthNet providers. It is okay if a health care student gives me or my child medical care or services under the guidance of HealthNet's licensed providers.

Using state and national guidelines, HealthNet providers and other staff may give my child (14 years and older) private health care for birth control, sexually transmitted infection (STI) screening and treatment, and referral for substance abuse treatment. If my child requests these services, this information will not be shared with me unless my child states otherwise.

Payment

I agree to pay for the care and services my child or I get. If I have health insurance, HealthNet may collect money from my insurance company to pay my bill. I know I must pay what my insurance does not cover. I know that if I do not pay, my account will go to collections.

Privacy

We will use and may need to share your personal health information to treat you, get payment for the care we give, and run our business. To help you understand how we protect your health information and how to manage your health information, please read the "Notice of Privacy Practices" booklet.

Indiana Health Information Exchange

I know HealthNet and other local health care organizations share information in a health information exchange. This exchange allows providers to view patient health information from other organizations when they care for a patient. A provider from another health care organization who is treating me, or my child may get and use our health information to give us the best care. I also understand that a HealthNet provider may get and use my or my child's health information from another health care organization.

HealthNet has given me the newest copy of the "Notice of Privacy Practices". The "Notice of Privacy Practice" is also on HealthNet's website. I know that the New Patient Handbook can be found on HealthNet's website at www.indyhealthnet.org. I understand that if I cannot access this online or if I want a paper copy, I can ask for one. I have read and I understand the above.

No-Show/Cancellation

See our "New Patient Handbook" for our no-show and cancellation policy.

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Virtual Care Informed Consent

Virtual care allows my provider to diagnose, consult, treat, and educate using interactive audio, video, web, remote monitoring or data communication about my treatment.

I understand:

I have a right to privacy with virtual care under the same laws that protect the privacy of my medical information for in-person visits. Any information I share during my visit, is usually private.

There are some exceptions, like having to report child, elder, and dependent adult abuse. If my provider thinks I am a danger to myself or others, they have the right to break privacy to prevent the threat of danger.

While I may benefit from virtual care, there is no guarantee that all treatment will be effective.

There are risks unique to virtual care. Some of these risks include the chance that communication by my provider could be disrupted, interrupted, or distorted by technical failures. Communication could be accessed by persons who are not permitted to have my medical information.

Virtual care treatment is different from in-person treatment and my provider may decide I would be better served by an in-person visit.

Virtual care is not for medical emergencies. I will not rely on virtual care for immediate care needs.

I can stop my consent to virtual care at any time by giving written notice.

I have read, understand, and agree with the information above.

Patient/Guardian Printed Name: _____ Date: _____

Patient/Guardian Signature: _____ Relationship to Patient: _____

Staff Printed Name: _____ Staff Title: _____

Staff Signature: _____