



# Communications & Insurance Consent Form

Phone number we can call for reminders, abnormal tests, or leave a message for you:

\_\_\_\_\_

Can we text you at the above number to remind you of your appointment or ask you to call myHealth? YES NO \*Standard messaging and data rates apply!\*

Name an adult we can contact in case of a medical emergency (like if we need to call 911):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Number: \_\_\_\_\_

**YOUR EMAIL ADDRESS:** \_\_\_\_\_

We ask for your email address for your patient portal account. Patient portal allows you to go online and view upcoming appointments you have scheduled, or to view certain details regarding your previous appointments or labs. Our patient portal is a secure, online system that sends an activation email to you when you create your account. We also ask for your email address in the event we are unable to contact you by phone, and need to direct you to call us.

Can we contact you at the above email to remind you of your appointment or ask you to call myHealth if we are unable to reach you by phone? YES NO

Patients are advised that unencrypted emails pose a greater risk to the confidentiality of protected health information (PHI) than alternative modes of communication. Pursuant to the changes to HIPAA reported in the HIPAA/HITECH Omnibus 2013 Final Rule patients may consent or request to be contacted and to receive PHI by email, but they must opt in. **Please note:** Email is not the recommended way in which to contact a medical professional or scheduler. If you need to speak to a medical professional, make an appointment, or ask questions about your insurance, myHealth's main phone line is the best and most secure way to do so.

**Patient consent for myHealth to open and manage mail on my behalf for the purposes of obtaining payment or coordinating care**

I understand that this mail may include:

- Eligibility determinations for the Minnesota Family Planning Program, if I use myHealth as the mailing address on my MFPP application.
- Requests for additional information regarding your eligibility, or proofs of identity and income, from the Department of Human Services.
- Requests for further information regarding MN Health Care Programs eligibility for specific dates of service from myHealth's contracted lab.

In the event that myHealth receives mail addressed to me relating to my Medicaid coverage I give permission for myHealth staff to open that mail, and to notify me of any action I am required to take. I understand that I can revoke this consent at any time, and that myHealth has a responsibility to answer any questions I may have regarding the management of my mail. If I refuse to give consent, I understand that this may prevent payment for my services, and myHealth may need to contact me to make alternative arrangements.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Form Continues on Other Side →

**Do you have health insurance? (Please check at least one)**

- I have state medical insurance through the Minnesota Family Planning Program (MFPP), Medical Assistance or MNCare.  
Type/Name: \_\_\_\_\_ Sub ID# \_\_\_\_\_
- I have private health insurance through my parents or employer.  
Type/Name: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
*Please present your card to the receptionist. We may call you for more information if you choose to have us bill your insurance.*
- I am uninsured: I do not have any health insurance.

**myHealth will bill for the Minnesota Family Planning Program (MFPP), Medical Assistance and approved MNCare insurances. These programs keep reproductive visits confidential: you will not receive any mail at home for family planning and STD-related visits.**

**PLEASE CHECK AT LEAST ONE:**

- I give permission for myHealth to bill my Minnesota Family Planning (MFPP), Medical Assistance, or MNCare. I understand that my reproductive services will be confidential.
- I give my permission for myHealth to bill my health insurance for ALL services, including reproductive services. I understand that this will make my visit non-confidential: my insurance may send home mail relating to my visit, and myHealth may send me a notification of any services my insurance does not pay for if I request it.  
  
I wish to designate an address *other* than my home address at which to receive mail relating to insurance and fees for my visits: **YES NO**
- I give my permission for myHealth to bill my health insurance for non-confidential services. My reproductive services will remain confidential. My insurance may send home mail relating to visits for which insurance was billed, and myHealth may send me a notification of any services my insurance does not pay for if I request it.
- I do not give permission to myHealth to bill my insurance for any services in order to protect my confidentiality.

**Client signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Protected Health Information Consent**

I have been given a copy of the *Notice of Health Information Practices* and understand it provides information about how myHealth may use and disclose protected health information. I understand that the *Notice* is available for me to review and that I may request another copy at any time.

I understand that myHealth may use and disclose my *protected health information* without authorization for treatment, payment, or health care operations. *Protected health information* is information myHealth creates or receives that identifies the patient, including demographic information, relating to the patient's physical or mental health, the provision of health services, and to the collection of payment for providing services.

If you understand the information in this section, please sign and date below. If you do not understand everything in this section or have questions you want answered, please speak with a myHealth staff person.

**Client signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_