Communications & Insurance Consent Form

Your phone number: _____

Can we text you at the above number to remind you of your appointments? YES NO
Standard messaging and data rates apply!

Email address: _____

Please check these boxes:

- ☐ I understand I may be called to discuss my care.
- ☐ I understand I may be texted or emailed with a notice to call myHealth to discuss my care.

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

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.

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: _____ 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 to the best of my knowledge.

PLEASE CHECK AT LEAST ONE:

- ☐ **Bill Reproductive Care Confidentially:** 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.
- ☐ **Bill All Services:** 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.
- ☐ **Bill Primary Care Only:** 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.
- ☐ **Do Not Bill:** I do not give permission to myHealth to bill my insurance for any services to protect my confidentiality.
- ☐ **Uninsured:** I am not aware that I have insurance, but I give my permission to bill active Minnesota Health Care Program insurances for all confidential services if the insurance is found to be active.

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** Address: _____

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: _____