212 S 4th St, Grand Forks, ND 58201
607 Towner Ave, Larimore, ND 58251

Patient Privacy, Rights, and Responsibilities Acknowledgement

As a patient at Spectra Health, I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy with regards to my protected health information. Additionally, I understand that if I choose to receive services for substance use disorder treatment at Spectra Health, that these records have further privacy protections covered by 42 CFR regulations (Part 2).

I understand that my health information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among my health care providers who may be directly or indirectly involved in that treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations, such as quality assessments and practitioner certifications.

HIPAA and Part 2 Covered Services

I acknowledge that I have received, read, and understand Spectra Health's *Notice of Privacy Practices* document describing the uses and disclosures of my health information as it relates to HIPAA and Part 2 protections (when applicable). I understand that I may ask questions about the information contained in this notice at any time, and that I may contact Spectra Health at any time to request a current copy of the *Notice of Privacy Practices* document.

Patient Rights and Responsibilities

I acknowledge that I have received Spectra Health's *Patient Rights and Responsibilities and Zero-Tolerance Statement* document describing the general expectations for receiving services as Spectra Health. I understand that I may ask questions about the information contained in this notice at any time, and that I may contact Spectra Health to request a current copy of the *Patient Rights and Responsibilities and Zero-Tolerance Statement* document.

Signed:

_____ _____

Patient Name, printed Parent/Legal Guardian Name, printed

_____

Patient Signature Date

_____

Parent/Legal Guardian Signature Date

Authorization To Provide Treatment

patient sticker

Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Spectra Health for services rendered. I understand that I am financially responsible for all charges and accept responsibility for any fees for services not covered by my insurance or sliding fee scale assignment. I certify that the information I have reported regarding my insurance coverage is correct. I hereby authorize Spectra Health to release all information necessary to secure the payment of benefits from my insurance carrier. I further agree that a photocopy of this agreement shall be as valid as the original.

Outside Lab and Radiograph Processing

Spectra Heath partners with outside organizations, such as Altru, for processing certain labs and x-rays. When processing by an outside organization is required, I understand that I am subject to those agencies' Patient Financial Rights & Responsibilities and may receive applicable billing from these sources. If you are uninsured and on the Spectra Plan, we may be able to assist with the cost of specific labs/x-rays processed at Altru.

Spectra Health No-Show Policy

I understand that after two broken appointments in a six-month period at Spectra Health Dental Clinic, I am ineligible for treatment for six months. I understand that if I am late by 10 or more minutes to a medical appointment, I will be asked to reschedule my appointment. I understand that two consecutive broken specialty mental health appointments or chemical dependency evaluations will result in the cancellation of any outstanding appointments after the second missed appointment.

Electronic Medical Records Affiliation Agreement

My health records with Spectra Health will be stored in the same Electronic Medical Record as Altru Health Systems. While your information could be visible to certain health care providers at Altru, providers only access charts of their patients for provided care. Altru and Spectra Health have methods of monitoring for inappropriate employee access to patient charts and disciplinary policies related to inappropriate chart access.

I Authorize My Spectra Health Care Team to Share Relevant Information Regarding My Care.

As an integrated care setting, Spectra Health providers work as a team. This may require sharing relevant information among your Spectra Health care team.

Substance Use Disorder and Mental Health Treatment

I understand that my substance use disorder and mental health treatment records are protected under the federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written authorization unless otherwise provided for by the regulations.

Continued on next page...

Behavioral Health and Primary Care Telehealth Consent

I consent to receive primary care and behavioral health services through telehealth when appropriate or available. I understand that the provider of my visit will be in an alternate approved location. A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. Spectra Health telehealth service uses a secure web-based system for transmitting audio and video data. To ensure privacy, data is encrypted at the highest level available for telehealth.

I understand that while telehealth services are considered a proxy for direct face-to-face treatment, certain risks exist. I understand that risks for using telehealth services can include, but are not limited to, technological interruptions, unauthorized information access, technological difficulties, or the need to have a visit performed in-person.

I understand that I can decline telehealth services at any time with no impact to future care, treatment, or program benefits. I understand that the same confidentiality laws and protections for face-to-face visits apply to telehealth visits including the expectation of privacy, confidentiality, and to be informed of all people who will be present during my visit. I understand that I can access information from a telehealth visit or request records from a telehealth visit by submitting a written request to Spectra Health. I acknowledge that information related to my telehealth visit will not be released without my written consent. I acknowledge that billing will occur from my practitioner and may include a facility fee from the site from which I am presented.

Informed Consent and Authorization to Treat

I understand I have the right to be told the reason for the treatment/procedure(s), the benefits or risks associated with it, and other treatment options. I understand that services provided at Spectra Health are voluntary and, I can refuse service at any time. I also authorize Spectra Health to do exams (including ocular dilation), treatments, order diagnostic tests, and to provide medications that the provider thinks are necessary to stay healthy. If I choose to participate in telehealth services, I acknowledge that my provider will explain to me how the video conferencing technology will be used.

I accept these authorization terms and request Spectra Health provide me and/or my family with care.

Patient Name: _____

Signed:

_____ _____

Patient (or patient's legal guardian) signature Date

Legal guardian name, if applicable: _____

Relationship to patient: _____

SpectraPlan Eligibility Screener

Spectra HEALTH | Redefining Care

Today's Date: _____

Responsible Party: _____
Last Name First Name, Middle Initial

Billing Address: _____
Street City State Zip Code

Phone: _____ Social Security #: _____

Date of Birth: _____ Email Address:_____

Family Size: _____ Annual Income: _____
(the total number of people in your household) (the total amount of money your household earns in a year)

OR indicate both your family size and gross annual income range by circling them in the table below:

	ELIGIBLE FOR SPECTRAPLAN DISCOUNT PROGRAM				NOT ELIGIBLE
	GREEN - 100% FPL% 0%-100%	BLUE - 75% FPL% >100%-133%	GRAY - 50% FPL% >133%-167%	WHITE - 25% FPL% >167%-200%	FPL% > 200%
FAMILY SIZE	INCOME	INCOME	INCOME	INCOME	INCOME
1	$0 - $15,960	$15,961 - $21,227	$21,228 - $26,653	$26,654 - $31,920	$31,921+
2	$0 - $21,640	$21,641 - $28,781	$28,782 - $36,139	$36,140 - $43,280	$43,281+
3	$0 - $27,320	$27,321 - $36,336	$36,337 - $45,624	$45,625 - $54,640	$54,641+
4	$0 - $33,000	$33,001 - $43,890	$43,891 - $55,110	$55,111 - $66,000	$66,001+
5	$0 - $38,680	$38,681 - $51,444	$51,445 - $64,596	$64,597 - $77,360	$77,361+
6	$0 - $44,360	$44,361 - $58,999	$59,000 - $74,081	$74,082 - $88,720	$88,721+
7	$0 - $50,040	$50,041 - $66,553	$66,554 - $83,567	$83,568 - $100,080	$100,081+
8	$0 - $55,720	$55,721 - $74,108	$74,109 - $93,052	$93,053 - $111,440	$111,441+
9	$0 - $61,400	$61,401 - $81,662	$81,663 - $102,538	$102,539 - $122,800	$122,801+
10	$0 - $67,080	$67,081 - $89,216	$89,217 - $112,024	$112,025 - $134,160	$134,161+

Spectra Health offers a sliding fee discount program, known as the SpectraPlan. The family size and income information collected on this form indicates whether your household may qualify for the discount program. You can choose to decline participation in the discount program. By choosing to refuse participation in the SpectraPlan, you are declining ANY possible discount on future services. **All services at Spectra Health are subject to a Nominal Fee, regardless of your participation in the SpectraPlan.**

Please note: if you are interested in Spectra Health's SpectraPlan, a separate application as well as income verification is required for final discount program determination. The SpectraPlan can assist with the cost of care for services at Spectra Health.

Please check **only one** box below:

☐ **Yes**, I WANT to apply for the SpectraPlan. I want to be contacted by Spectra Health staff to discuss completing a full SpectraPlan application and providing income verification.

☐ **No,** I DO NOT WANT to apply for the SpectraPlan. I do not want/need any discount on future services I receive at Spectra Health. I understand I can apply for the SpectraPlan at any time in the future if needed.

Common reasons for *not* participating:

- A third-party agency is responsible for patient payment.
- You are not eligible to participate due to income.
- You are not interested in participating.

X_____
Signature **Date**

Spectra Health Social Services Department would be pleased to assist you in the full SpectraPlan application process. Please schedule an appointment with registration or call 701-757-2100 (option 6) for further assistance. Please note the SpectraPlan discount program can NOT be applied to reduce any monthly Medicaid recipient liability for those patients for which this applies.