Tule River Indian Health Center, Inc.
380 N. Reservation Rd., Porterville, CA 93257
Phone: (559) 784-2316, Fax: (559) 781-6514

CONSENT FOR TREATMENT

I, the undersigned patient/guardian consent to authorize the Medical and Dental Provider(s) including Mid-Level Provider(s), and Emergency Personnel employed by the Tule River Indian Health Center, Inc. to administer/perform examinations, treatments, diagnostic procedures and immunizations against disease which now or during the course of the patient's care deemed advised.

Printed Patient Name ______________________________ Patient or Guardian Signature Date

CONSENT TO TELE-VISITS

I, the undersigned, patient/guardian consent to authorize Telehealth/Telemedicine (Televisits)/Virtual Visits involving the use of electronic communications for the purpose patient care. Televisits may be used for diagnosis, therapy, follow-up and/or educational purposes. I understand that, televisits sometimes require transmission, via the Internet or tele-communication devices, of health information, which may include progress reports, assessments, or other health related documents in forms of video, picture, text messages, audio or other digital forms of data. I understand that, I can be given information about test(s), treatments(s) and procedures (s), through the televisit. I understand that, the privacy and confidentiality laws (HIPAA) also apply to televisits. As with any Internet or telephone based communication, I understand that there is a risk of security breach. I understand that, televisits may not always be possible due to disruptions of signal or problems with the Internet which may cause reception problems that prevent effective interaction. I hereby release and hold harmless Tule River Indian Helath Center, Inc. from any loss of information due to technical failures associated with my televisit. I understand that, I do have the right to withdraw consent to the use of televisits at any time and can continue my care in-person. I understand that the withdraw of my consent for televisits, will not affect any future services or care benefits to which I am entitled.

____ I have the right to refuse these types of visits and I do not consent to Tele-Visit appointments.

Printed Patient Name ______________________________ Patient or Guardian Signature Date

CONSENT TO BILL

I, the undersigned authorize TRIHCI to file a claim with my insurance carrier for services rendered. I authorize TRIHCI payment of benefits directly, for services provided to my dependent or me. I understand that I am responsible for providing insurance/billing information to TRIHCI or may be held responsible for charges not covered/paid by my insurance.

Printed Patient Name ______________________________ Patient or Guardian Signature Date

Approved: 02/07/2024 (MSC:6-0-0)