**CONSENT FOR SERVICES**

1. **CONFIDENTIALITY**

As a client of Asian & Pacific Islander Wellness Center’s (APIWC), the conditions of services have been explained to me to my satisfaction. I understand that records concerning my participation will be retained and that such information will be kept confidential per HIPAA regulations. No information about me will be released to agencies or persons outside of APIWC without my written authorization, except in case of a medical emergency or as permitted by current law.

1. **CONSENT FOR COMMUNICATION & FOLLOW-UP**

I understand that it may be necessary for me to be contacted on an ongoing basis. If I am to be contacted by telephone, through mail, or email, no mention of any specific medical condition shall be made verbally or in writing unless I have given explicit verbal or written consent to do so. When phone messages are left, only the name and phone number of the caller from the program will be given. If translation services are needed for forms and appointments, they will be provided to me over the phone or in person.

1. **INTERPROGRAM COMMUNICATION**

I understand that I also consent to communications among APIWC agency staff, other onsite service providers and treatment information (both medical and psychiatric).

1. **BILLING**

I understand that APIWC will bill my insurance for services provided. If I do not have insurance, APIWC will help evaluate and facilitate insurance enrollment through MediCal, Covered California and/or the Marketplace. I understand I will also be evaluated on a sliding fee scale for services at The Wellness Clinic, but will not be turned away for lack of funds.

**E.MINOR’S RIGHTS**

I understand that if I am under the age of 18 I am entitled to access sensitive health services including: pregnancy testing and evaluation, STI screening/treatment, Mental Health Services and Drug/Substance abuse services without parental notification.

**F. PRESCRIPTION HISTORY**

I understand that by enrolling, I give consent to The Wellness Clinic to review my prescription medication history to reduce any interaction risks.

**G.SERVICE ENROLLMENT**

I understand that the following services offered by APIWC are available for me to access and I request to receive the following:

🞎 Case Management 🞎 The Wellness Clinic

🞎 Peer Advocacy 🞎 Psychiatric Services

🞎 Treatment Advocacy 🞎 Individual Mental Health Services

🞎 Treatment/Peer Support Groups 🞎 Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*This publication is part of a series of manuals that describe models of care that are included in the HRSA SPNS Initiative* Building a Medical Home for HIV Homeless Populations*. Learn more at* <http://cahpp.org/project/medheart/models-of-care>