Logan & Seiler, Inc
406 South Main St
Charleston, MO 63834
www.semorx.com
contactus@semorx.com
573-683-3307

# 1st: VERIFY that we have a signed:

# Authorization for the release of protected health information (PHI) / HIPAA release on file at the pharmacy before moving forward. If not, have the patient sign our HIPAA release.

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# CONSENT FOR SERVICES

CONSENT TO SERVICES: I hereby consent to and authorize such services as prescribed and fully explained to me by the Community Health Worker (CHW). It is not possible to make guarantees concerning the results of services. I acknowledge no such guarantee has been made to me. I understand I will have the opportunity to discuss all care and/or services proposed to me with the CHW and I may refuse to consent for care services if I do not want to proceed with such course of services. I will provide the CHW with accurate information regarding my medical, sexual, drug and/or alcohol history, and personal or social concerns which may impact my health or medical care to ensure proper service, care, and referral for needed services.

I understand that if I am more than 15 minutes late for my appointment or home visit I may not be seen and will need to reschedule my appointment. I am responsible for notifying the appropriate CHW –at least 24 hours in advance – if I am unable to keep my scheduled appointment. To the best of my ability, I will be an active participant in my care. I am responsible for reporting any changes in my health status to my CHW so that I can receive prompt and appropriate education and referral services.

_____ INITIAL

If during an appointment of home visit with a CHW my situation is an emergency I will call 911 for assistance or go to the nearest emergency room.

_____ INITIAL



**I HAVE CAREFULLY READ AND FULLY UNDERSTAND THIS CONSENT AND AGREEMENT. I HAVE RECEIVED A COPY OF THIS CONSENT/ AGREEMENT, AND AM DULY AUTHORIZED TO EXECUTE THE ABOVE AND ACCEPT THE TERMS AS DESCRIBED. I UNDERSTAND THIS CONSENT/AGREEMENT IS EFFECTIVIE UNTIL REVOKED IN WRITING.**

_____ _____
Signature of Client/Parent/Legal Representative Date

_____ _____
Witness Date

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# INFORMED CONSENT FOR CASE MANAGEMENT

Your health care case management is voluntary and confidential. No information will be given out about you without your written permission except as required by law or to provide services to you in compliance with federal privacy and security standards.

Please note:

1. We are mandatory reporters of Statutory Sexual Seduction (N.R.S. 200.364). This means that if you are 15 years of age or younger and are having sex with someone 18 years of age or older and you tell us, we must report it to law enforcement.
2. We are also mandatory reporters of Child Abuse and Neglect (N.R.S. 432B.220). This means that if we have cause to believe that there is any kind of abuse or neglect of a minor occurring, we must report it to law enforcement.
3. We are also mandatory reporters of lewdness (sex) with a child under the age of 14 (N.R.S. 201.230). This means that if we have a cause to believe that there are any kinds of vulgar or indecent activities occurring involving a child under the age of 14, we must report it to law enforcement.

**I have the right to know everything about my care and am encouraged to ask questions.**



I understand that in order for us to provide the services I request, I may need to disclose information of a personal nature and regarding my medical history. These may include:

- Date of birth
- Past/Current medical issues
- Contact information
- Tobacco/alcohol/substance use
- Medications
- Family dynamics

I have read (or have had read to me) the above information, understand this information, and give my permission for case management from the Community Health Advocate.

Signature:_____ Date: _____

Witness:_____ Date:_____