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PATIENT RESPONSIBILITIES FORM

Doctors, their staff, neighborhood clinics, hospitals, and many others are volunteering their services to help you get and stay well. **This is not insurance or a government program**. Our help may end at any time, for any reason and may be limited. Emergency room expenses and ambulance services **are not covered**. Your responsibilities, the assistance available and other conditions may change at any time. By signing this form, or by using these cards in any way, you agree to follow the Patient Responsibilities below, and you give Cumberland HealthNET (CHN) permission to verify with state and other agencies what you have told us. Providing false information or neglecting to provide important information regarding your healthcare insurance, income, residency or illness will result in loss of CHN benefits and you having to pay for the services received.

CLICK TO ACCEPT EACH OF THESE

_____ 1. I agree to allow Cumberland HealthNET (CHN) to schedule my first appointment with a primary care physician.

_____ 2. I agree that I will not call any specialist to book an appointment. I will ask my primary care doctor to do so. I understand that I may be responsible for the cost of care provided outside of my primary care physician's office.

_____ 3. I agree to keep every medical appointment and show up on time or give at least 24 hour notice to cancel. I understand that giving less than a 24 hour notice will result in immediate discharge from the program.

_____4. I understand that if I reschedule my doctor's appointment two (2) times I will be discharged from the program.

_____ 5. I understand that the doctors providing care are not responsible for assisting me with obtaining disability and ***if*** they do so it will be at a separate charge determined by each individual practice. I further understand that this is a service that is not provided by CHN and I am responsible for paying any required fees.

_____ 6. I agree to show my CHN Program ID each time I see my assigned primary care physician.

_____ 7. I agree to follow my treatment plan, for example, get prescriptions filled and take medication as directed, attend follow up appointments and meet with my case manager. I understand that I am responsible for asking questions when I don't fully understand my health problem or plan of care.

_____ 8. I agree to provide accurate information about my present illness, medication, past medical or health history and report any changes in my condition to my physician and case manager.

_____ 9. I agree to provide complete and accurate information about my diagnosis, identity, residency, income and other information/documentation that CHN staff may need to verify eligibility and arrange appropriate care.

_____ 10. I agree to immediately contact the enrollment specialist at CHN if my income, address or phone number changes or if I get **Medicare, Medicaid, private insurance, other health insurance or benefits.**

_____ 11. I agree to apply for Medicaid or other assistance programs if CHN Program staff asks me to.

_____ 12. I understand that **I am responsible for understanding any financial commitments to providers and honoring them**.

_____ 13. I have read the ***Notice of Privacy Practices*** and understand my information will be shared with other individuals, organizations and agencies who are involved in treatment and operations with CHN.

By signing below, I confirm that I understand and agree to the above conditions. I also understand that if I do not follow all the Patient Responsibilities listed, then I will lose my CHN benefits. If you have any questions please call 910.483.6869.

_____ _____

Patient Signature **Date**