



## **Check Hep B Patient Navigation Program**

### **Program Description/Patient Consent**

---

Please read this Check Hep B Patient Navigation Program description to understand the program and your role before you agree to participate.

If you have questions, contact \_\_\_\_\_.

You can keep a copy of this form.

#### **What is the purpose of Check Hep B Program?**

The Check Hep B Patient Navigation Program provides support to help people living with hepatitis B (Hep B) get through medical evaluation and treatment, if recommended.

Check Hep B services are provided by Patient Navigators, who will help you: understand Hep B, find support services, get into medical care and through treatment, if recommended, and stay healthy after treatment.

#### **What is expected of people who enroll in this program?**

Program participants will need to:

1. Attend all scheduled appointments with your Patient Navigator and Medical Provider. If you cannot attend an appointment, reschedule in advance.
2. Work with your Patient Navigator to understand how Hep B affects your health, follow medical care recommendations, and overcome challenges to completing medical evaluation and treatment, if recommended.
3. If you go on Hep B treatment, take your medications as prescribed for the whole time you are on treatment.

#### **How will enrolling in this program affect my privacy?**

- All staff in the Check Hep B program are trained to protect your privacy and the confidentiality of your information.
- Your Patient Navigator will learn about you by asking you questions, by reading your medical charts, and by speaking with other providers involved in your care if you give permission. This information will be used to suggest the best care for you.
- Information collected may include, but is not limited to: your medical history, dates and types of health-related appointments, services and benefits received, demographic information (such as, race, gender, country of birth), risk behaviors, and medications.
- Reports on this program will not include your name or personal information that could be used to identify you.

**What if I do not want to participate, or if I want to stop after I enroll?**

Participation in this program is voluntary. You may end your participation at any time. If you wish to end your participation, please inform your Patient Navigator. Check Hep B program staff can also end your participation in this program at any time for medical or administrative reasons. If you end your participation in Check Hep B, you can still receive other medical or social services at the organization.

**Statement of Agreement**

---

I, *(print patient name)* \_\_\_\_\_, understand the information provided above and agree to participate in the Check Hep B Program at *(print agency name)* \_\_\_\_\_.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**Date (mm/dd/yyyy)**

**Check Hep B Program Staff:**

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

**Initials**

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
**Date (mm/dd/yyyy)**