CenterWell ACE

PATIENT AGREEMENT AND CONSENT TO TREAT

Patient Name: ____________ ____________ __________ __________

Last First MI Date of Birth

Thank you for choosing (Enter Facility Name) as the provider organization for your healthcare needs. In accordance with applicable state and federal law, we are required to obtain your permission or consent to perform services for and on your behalf. It is important that you understand the information below. If you have any questions or concerns regarding the information provided, we are happy to assist you. The first four boxes are required and the last two are optional. To opt-in, please place your initials on or next to each *optional* block to acknowledge that you understand and accept each statement. If you wish to decline, do not initial.

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, hereby voluntarily consent to medical care and treatment provided through this provider organization, as ordered by my health care provider. This includes my consent for all medical services provided under the general or specific instructions of my health care provider, including treatment by a nurse practitioner or physician assistant, and other health care providers or designees under the direction of a physician as deemed reasonable and necessary by my provider.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me because of treatments or examinations that I received or will receive. I understand that I have the right to discuss my treatment plan with my provider and to discuss the purpose, and potential risks and benefits of any tests or procedures that are ordered or recommended by my provider.

I understand that students in the medical field under appropriate supervision may observe or assist in the delivery of my medical care and that I have the right to refuse such services provided by students at any time.

ASSIGNMENT OF BENEFITS

I expressly request that payment of and hereby assign payment of authorized medical benefits be made on my behalf directly to this provider organization for medical care and treatment(s) furnished to me. I authorize this provider organization to release any medical information to my health insurance carrier and/or other third-party payors that is necessary to collect payments, process related health insurance claims, and/or to verify plan benefits in accordance with the Health Insurance Portability and Accountability Act (“HIPAA”) standards and applicable state privacy laws. I authorize payment of service(s) otherwise payable to me under the terms of my private, group, employer’s plan, or group health insurance plan directly to this provider organization. I expressly authorize this provider organization to be considered my authorized representative with respect to all payments and/or claims related to medical care and treatments furnished to me by this provider organization. I hereby authorize that a photocopy of this form be valid as the original. If the medical benefits are not assignable to this provider organization or if I receive payments from my insurance provider or any other third-party payor for services rendered on my behalf by this provider organization, I will forward such payments to this provider organization immediately upon receipt.

PAYMENT OF SERVICES

If services are not covered or covered charges are not paid in full including, but not limited to, any co-payment, co-insurance and/or deductible, or charges that are not covered by my insurance provider or other third-party payor, I agree to pay. I agree to be responsible for all reasonable attorneys’ fees and collection costs resulting from my failure to pay any fees or amounts for which I am financially responsible.

I agree that in order for this provider organization and its collection agents to service my account or to

collect any amounts I may owe, the provider organization and its collection agents may contact me by telephone at any telephone number, including my cellular telephone number, that I have provided to the provider organization, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. If applicable, data charges and rates from my cellular carrier may apply.

NOTICE OF PRIVACY PRACTICES

I acknowledge and agree that I have received a copy of the Notice of Privacy Practices. I understand that the Notice of Privacy Practices may be updated periodically and that a copy of the updated Notice of Privacy Practices will be provided to me upon request.

CONSENT TO TELEPHONE CALLS (INCLUDING CALLS TO MOBILE PHONE), EMAILS, TEXT MESSAGES – ***Optional***

By initialing below, you acknowledge that you have read, understood, and agree to the following:

I understand that by providing a telephone number or email address, I am giving this provider organization and its affiliates, subsidiaries, parents, agents, vendors, and/or independent contractors the permission to contact me at that email or number (including via live, artificial, autodialed calls, computer-aided technology, pre-recorded messages, and text messages, unless prohibited by applicable law). Message and data rates may apply. I understand that this consent will remain in effect unless I opt out by following the opt out directions, if applicable, or by notifying the provider organization, in writing, that I revoke my consent. I may change these preferences at any time.

I also understand that I may receive calls, emails and text messages regarding services, billing matters or activities (“Other Communications”) provided by or on behalf of this provider organization and its affiliates, agents, and independent contractors. I hereby agree and authorize this provider organization and its affiliates, agents, and independent contractors to contact me via telephone calls, emails, and text messages for marketing purposes. I also acknowledge this means of communication is not considered secure for the transmission of private information.

Initials: ____

Telehealth Services - ***Optional***

By initialing below, you acknowledge that you have received a copy of the Telehealth Services Information

Sheet and that you have read, understood, and agree to the following:

Telehealth Defined

“Telehealth” is the practice of delivering health care services via HIPAA-compliant electronic and telecommunications technologies, including video conferencing software and other technology-assisted media. For purposes of this Patient Agreement & Consent, the term “telehealth” includes any services which may be referred to as “telemedicine.” It also includes services which may be referred to as “telemental,” “teletherapy,” or “telepsychology” (mental or behavioral health care services provided by a Specialist).

Benefits and Risks

Some of the benefits include enhanced communication (enabling communication with your provider or Specialist, wherever you may be, easier access to health care, and avoiding the need to travel to your provider’s office or to arrange for in-home provider services, as applicable. Some of the risks include,

without limitation, loss of records from failure of electronic equipment, power failure with loss of communication, and invasion of electronic records from outsiders (hackers). Further, some signs and symptoms which may be detected during an in-person examination may not be detected through telehealth. You acknowledge the risks of benefits of using telehealth and agree to hold harmless the provider organization from any such risks.

Privacy and Security

Telehealth visits will not be recorded by either party. Information disclosed during these visits is confidential and may not be disclosed without your written authorization, except where disclosure is permitted and/or required by law. Privacy laws protecting the confidentiality of your protected health information (PHI) apply to telehealth unless an exception to confidentiality applies (i.e., mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; you raise your mental/emotional health as an issue in a legal proceeding; consultation/coordination of care with other treating providers). Software used during telehealth visits is secure and protected.

Withdrawing Consent

You may withdraw your consent to telehealth services at any time without affecting your right to future care, services, or program benefits to which you would otherwise be entitled. Consent must be withdrawn in writing.

Initials: ____

By signing below, you indicate that you have read, understood, and agree to the consent for Medical Treatment, Assignment of Benefits, Payment of Services, Notice of Privacy Practices, and authorizations described above and that each consent and authorization will remain fully effective until it is revoked in writing.

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Printed Name of Patient/Parent/Personal Representative

______________________________ ______________________________

Signature of Patient/Parent/Personal Representative* Date

**If you are signing as a Personal Representative of the Patient, please describe your authority to act for this Patient and provide any corresponding documentation (power of attorney, guardianship order, healthcare proxy/surrogate, etc.):*