GENERAL PATIENT CONSENT

Patient Name: _____ _____ _____
Last First MI

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 authorization 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 would be happy to assist you. Please place your initials each block to acknowledge that you understand and accept each statement. In the event that you wish to decline a particular provision, please print the word "Declined" beside your initials so that we may address your related concern or, where possible, complete any forms required to formalize your refusal.

CONSENT FOR MEDICAL TREATMENT.

I, the undersigned, hereby 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.

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

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.

I understand that if I need to review or obtain a copy of my medical records, I must complete the access request form available at this location. This form will allow me or a person that I authorize to obtain copies of my medical records.

Initials: _____

ASSIGNMENT OF BENEFITS.

I request that payment of authorized medical benefits is 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 hereby authorize that photocopies of this form to 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.

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PAYMENT OF SERVICES.

I agree to pay for services that are not covered or covered charges 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 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 and/or at any telephone number that its collection agents have obtained or, at any telephone number forwarded or transferred from any such telephone number, 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.

Initials: _____

NOTICE OF PRIVACY PRACTICES.

I understand that my protected health information may be used and disclosed without my authorization to allow for treatment, payment, and health care operations as described in the 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.

Initials: _____

SENSITIVE INFORMATION.

I understand that, unless I have requested restrictions in writing, the type of information that this provider organization may release to third parties may include certain sensitive medical records including, but not limited to, records regarding psychological treatment, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) infections, developmental disabilities, alcoholism, or drug dependence during any period of care and treatment. A form to request restriction of this type of information is available at this location.

Initials: _____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY.

I understand that it may be necessary for this provider organization and its health care providers to obtain information regarding prescribed medications that I am currently taking or have taken in the past for medical care and treatment purposes. I hereby authorize this provider organization and the health care providers to obtain and review my external prescription history from my current and former medical care providers, pharmacies, and drug monitoring agency.

This consent helps to facilitate accurate and efficient treatment with minimal inconvenience to you.

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TELEMEDICINE AND TELEHEALTH.

I understand that telemedicine or telehealth involves the use of secure interactive videoconferencing equipment and devices that enable a physician licensed by the state where my clinic is located, or a health care professional acting under the delegation and supervision of a physician licensed by the state where my clinic is located, to deliver heath care services to patients when located at different sites. Such health care services may include, without limitation, assessment, diagnosis, consultation, treatment, and monitoring of a patient at a separate location and the transfer of medical data, each as permitted by applicable law. All electronic transmission of data will be restricted to authorized recipients in compliance with the HIPAA and applicable state privacy laws.

I understand that there are risks and benefits of using telemedicine or telehealth services. Some of the benefits include easier access to medical care and avoiding the need to travel to the health care provider. Some of the risks associated with the use of telemedicine or telehealth services 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). In addition, signs and symptoms that may be detected during an in-person physical examination may not be detected through telemedicine. I understand that I have the option of seeing the health care provider face to face instead of participating in telemedicine or telehealth. I acknowledge the risks and benefits of using telemedicine and telehealth services and hereby consent to use of telemedicine and/or telehealth to perform medical treatment and services. I understand that I have the right to refuse to participate in a telemedicine visit or telehealth services and that my refusal will be documented in my medical records. I also understand that my refusal will not affect my right to future medical care or treatment by the provider organization.

I understand that certain in-home technology that I may select for use in my home, for example Amazon's Alexa and certain "smart" televisions, may have the capacity to "listen in" to activity in my home, including interactions during in-home health care visits. I understand and agree that I am solely responsible for configuring such equipment to ensure the privacy of communications with health care providers during any in-home visits or telemedicine appointments.

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CONSENT TO TELEPHONE CALLS (INCLUDING CALLS TO MOBILE PHONE), EMAILS, TEXT MESSAGES.

I understand that by providing a telephone number or email address, I am giving this provider organization and its agents the permission to contact me (including via autodialed calls, pre-recorded messages and text messages) regarding appointment reminders and general health reminders. I understand that this consent to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I also acknowledge this means of communication is not considered secure for the transmission of private information. If applicable, data charges and rates from my cellular carrier may apply.

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. If applicable, data charges and rates from my cellular carrier may apply. Further, I understand that I may, at any time, opt out of receiving Other Communications by following the opt out directions that accompany the Other Communications or by revoking entirely the authorization to send me Other Communications by notifying the provider organization in writing. I also acknowledge this means of communication is not considered secure for the transmission of private information.

Initials: _____

CONSENT FOR COORDINATION OF CARE BY COMMUNITY BASED ORGANIZATIONS.

I agree to allow this provider organization to coordinate my care with community based organizations ("CBOs") that provide social services throughout the community that may assist in meeting my healthcare needs. I realize that there are instances where I may need these social services as part of my treatment and care. I have the right to refuse the coordination of social services at any time.

Initials: _____

ADVANCE DIRECTIVES.

I understand that I have a right to prepare advance directives (medical decision-making tools that can assist me to communicate my wishes regarding my medical care and treatment if I am unable to communicate with my health care providers or family members.) I understand that I may provide this provider organization with a copy of appropriately completed and signed advanced directives.

Initials: _____

By signing below, you indicate that you agree to provide the consents and authorizations described above and that each consent and authorization will remain fully effective until it is revoked in writing.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed Name of Patient or Legal Guardian Relationship to Patient if Signed by Legal Guardian

GENERAL PATIENT CONSENT

Patient Name: _____ _____ _____
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Conviva & CenterWell it is important you are treated fairly.

Conviva & CenterWell do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Conviva & CenterWell complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Conviva & CenterWell, there are ways to get help.

- You may file a complaint, also known as a grievance:

Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
If you need help filing a grievance, call **1-877-320-2188** or if you use a **TTY,** call **711.**

- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services,** Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or at
- **U.S. Department of Health and Human Services,**
- 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201,

1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html.**

- **California residents: You** may also call California Department of Insurance toll-free hotline number:

1-800-927-HELP (4357), to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-2188 (TTY : 711) Conviva & CenterWell provide free auxiliary aids and services , such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Espanol (Spanish): Llame al numero arriba indicado para recibir servicios gratuitos de asistencia linguistica
Chinese （中文）：撥打以上電話可免費獲得語言協助服務
Vietnemese (Tiếng Việt): Gọi số trên để nhận dịch vụ hỗ trợ ngôn ngữ miễn phí
Korean (한국어) : 위 번호로 전화하시면 무료 언어지원 서비스를 받으실 수 있습니다.
Tagalog (Tagalog): Tumawag sa numero sa itaas upang makatanggap ng mga libreng serbisyo sa tulong sa wika
Russian (Русский): позвоните по указанному выше номеру, чтобы получить бесплатную языковую помощь.
French Creole (Kreyòl franse): Rele nan nimewo ki anwo a pou resevwa sèvis asistans lang gratis
French (Français) : Appelez le numéro ci-dessus pour recevoir des services d'assistance linguistique gratuits
Polish (Polski): Zadzwoń na powyższy numer, aby otrzymać bezpłatną pomoc językową
Portuguese (Português): Ligue para o número acima para receber serviços de assistência linguística gratuitos
Italian (Italiano): Chiama il numero sopra per ricevere gratuitamente i servizi di assistenza linguistica
German (Deutsch): Rufen Sie die obige Nummer an, um kostenlose Sprachassistenzdienste zu erhalten
Japanese （日本語）：上記の番号に電話して、無料の語学支援サービスを受けてください
Navajo (Diné bizaad) Be moasi tlo-chin be ah-jah a-chin tse-nill a-keh-diglini be-la-sana yil-doi a-kha
Arabic (عربي): اتصل بالرقم أعلاه لتلقي خدمات المساعدة اللغوية المجانية