Patient Consent Form Adult

Notice of Privacy Practices/Advance Directive Acknowledgement/ Designated Representative

By signing this Consent Form, you give ConnextCare permission to treat you and use and disclose protected health information about you for treatment, payment, healthcare and/or dental care and treatment. This excludes only restrictions specified below to which we have agreed. *Protected health information* is individually identifiable information we create or receive, including demographic information, relating to your physical/dental or mental health, for the provision of healthcare services to you, and to the collection of payment for providing healthcare/dental services to you.

By signing this Consent Form you are giving ConnextCare permission to schedule both in-office and telehealth appointments. A telehealth appointment may be conducted via telephone, Greenway, other HIPAA compliant platforms. In-office and telehealth appointments will be billed accordingly and in adherence to state and federal requirements.

Our Notice of Privacy Practices provides information about how ConnextCare may use and disclose protected health information. You have the right to receive a copy of our Notice of Privacy Practices and Patient Bill of Rights before signing this Consent Form, they have been sent to you electronically. By signing this consent form, you acknowledge that you have received/been made aware of our ***Notice of Privacy Practices, Non-Discrimination Notice,*** and the ***Patient Bill of Rights***. You can also review them on the ConnextCare website or request a hard copy any time at the front desk.

If you do not sign this Consent Form, ConnextCare has the right to refuse to provide treatment unless a licensed healthcare professional has determined that you require emergency treatment, or we are required by law to treat you. ConnextCare is required to document any circumstances in which we do not obtain your consent and carry out treatment. We will offer you a copy of this documentation should you decide not to sign this Consent Form.

You have the right to request that ConnextCare restrict how protected health information is used, disclosed, or re-disclosed for treatment, payment, healthcare or dental operations. ConnextCare is not required to agree to any restrictions, but if we do, we are bound by our agreement. If you wish to make a restriction, please request a copy of our Form to Request Restriction (CC 003.02). You have the right to revoke this consent at any time except where we have already made disclosures in reliance on your prior consent. A signed ***Authorization for Release of Medical Information*** must be completed to share information.

An ***Advance Directive*** is written document (form) that tells what a person wants or does not want if he/she in the future cannot make his/her wishes known about medical treatment. Preparing a few simple legal forms such as a ***Health Care Proxy, Living Will, MOLST, or DNR*** can help ensure that your health care wishes are followed and your health care decisions stay in the hands of people you trust. ConnextCare has advance directive forms available. If you choose not to accept a copy today, you can obtain a hard copy at the front desk at any time.

You understand that photographs, videotapes, digital, or other images may be recorded to document care, and consent to this. Images that identify you will be released and/or used outside the institution only upon written authorization from you or your legal representative.

- ☐ **I consent to billing and treatment at ConnextCare**
- ☐ **I received a copy of my Patient Rights, the Notice of Privacy Practices, and the Non-Discrimination Notice**
- ☐ **I understand that ConnextCare has Advance Directive forms available upon request**

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

The following people are my designated representatives for Health Care needs:

1) Name_____Relationship to Patient_____

Address_____

Phone Number_____

I am authorizing this representative to access my <u>Standard</u> Medical Information in the following situations:

____Test results
____Medication questions/refills
____Schedule/Cancel Appointments
____Financial
____Medical Records (Pick- up only)

I am authorizing this representative to access my <u>Sensitive</u> Health Information:

_____Substance Use Disorder
_____Mental Health Information
_____STD/HIV and Reproductive Information

2) Name_____Relationship to Patient_____

Address_____

Phone Number_____

I am authorizing this representative to access my <u>Standard</u> Medical Information in the following situations:

____Test results
____Medication questions/refills
____Schedule/Cancel Appointments
____Financial
____Medical Records (Pick- up only)

I am authorizing this representative to access my <u>Sensitive</u> Health Information:

_____Substance Use Disorder
_____Mental Health Information
_____STD/HIV and Reproductive Information

Patient Signature: _____**Date**_____

This form may be revoked at any time and will be updated each calendar year