Name:_____________________DOB:________MRN:____

Patient Consent and Treatment Agreement and Use and Disclosure of Protected Health Information

I hereby give my consent for Affinity Wellness & Consultants to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
(The Notice of Privacy Practices provided by **Affinity Wellness & Consultants** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Affinity Wellness & Consultants** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a Written request to **Affinity Wellness & Consultants.** With this consent, Affinity Wellness & Consultants may call my home, cell phone, or other Alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Affinity Wellness & Consultants** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal And Confidential.”
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Affinity Wellness & Consultants may decline to provide treatment to

With this consent, **Affinity Wellness & Consultants** may utilize telehealth/telemedicine services including but not limited to: e-mail, video conference, text message (SMS) using HIPAA secure connections
to my home or other alternative location to provide any items that assist the practice in carrying out TPO, such as appointment reminder
cards and patient statements. I have the right to request that **Affinity Wellness & Consultants** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Affinity Wellness & Consultants** to use and disclose my PHI to carry out TPO.

Signature of Patient or Legal Guardian

____

Print Patient’s Name
Date &Time

____

Permission for Diagnostic and Treatment Procedures

I, ____, hereby authorize Affinity Wellness & Consultants (AWC) , their employees and consultants to perform diagnostic and treatment procedures which, in their judgement,

may become necessary while under their care. I understand that I will be involved and engaged in my care and treatment. I understand that AWC utilizes the services of Independent Nurse Practitioners. If I require specialized and/or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of AWC. ______**initia**l

Confidentiality and Notice of Privacy Practices

Acknowledgment Medical and mental health information contained in all health records is strictly confidential and may not be released without express written permission from the patient or by a court order. I certify that I have been offered the HIPAA policy of this office and can obtain copy of my medical records at any time. Confidentiality and privacy are protected in all AWC business relationships to prevent the exchange of any patient-specific information without permission. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Family Educational Rights and Protection Act (FERPA), I have certain rights to privacy in regard to my protected health information (PHI). By signing below, I acknowledge that I have received, read, and understood AWC Notice of Privacy Practices in accordance with HIPAA HHS law. AWC reserves the right to change the terms of its Privacy Notice. If such changes are made, I understand that the Privacy Notice will be posted on the AWC website, and I can request a copy at any time. _______**initial**

Financial Responsibility and Authorization to Process Insurance Claims

AWC is a participating provider in limited insurance plans. If your insurance is accepted, we will bill your insurance for care rendered by our staff. However, if we do not accept your insurance and require care, by signing this consent you are agreeing to pay the fees not covered by insurance

such as co-pays, one-time fees, or membership fees on a continual cycle. The patient is responsible for co-pays at time of service and the remainder will be billed to insurance. However, if you are paying out of pocket, the cost is due in full at time of service. AWC has not opted out of Medicare. If you are a medicare patient, AWC currently does not see Medicare or Medicaid patients. Patients and clients are responsible for all charges for services incurred by themselves or dependent family members for services and care. Examples of charges include office visits, lab tests, x-rays, prescriptions, dental procedures, vision procedures, physical therapy, vaccinations, after-hour visits, and others. Patients and clients who are covered by health insurance, either by a family policy or an individual policy can submit for reimbursement through their own insurance company. However, care will not be denied for lack of insurance. A valid identification such as a current driver's license, passport, or other government-issued ID must be presented on initial and subsequent visit prior to treatment and services rendered. ________**initial**

No shows/Cancellations:

Additionally, our providers take time to make connections and provide high quality care for each patient. Thus, each visit is extended and comprehensive. For any no-shows or cancellations with less than 24 hour notice, a $25 fee will be incurred and added to the patient's outstanding bill. Care will not be rendered until this fee is paid in full. If a cancellation is no-fault of the client/patient and of natural disaster, emergency closing of the clinic or staff, this fee will be waived. ________**initial**

Safety

At AWC, safety, people, and accountability are our hallmarks and I Understand that I may be denied treatment or care for inappropriate behavior, lewd acts, violence toward other patients or staff, assault, threatening language or behavior, and/or expired id. I understand a refund will not be given if care has already been initiated. Any of these behaviors

may result in police involvement and/or formal charges with the proper and local authorities. _______**initial**

Slander, Defamation, Libel

We understand in today's environment of handling business ventures online and through social media is a mainstay in our culture. However, if there is a complaint regarding care rendered or lack thereof, we ask that it is handled off line and with the practice-client collaboratively. Slander, defamation, and libel on any social media or online platform will not be tolerated. If this is done, the patient/client understands that legal action will be initiated and can lead to lawsuit against the accuser or parties related to. ______**initial**

Non Narcotic Agreement

I understand that narcotics will not be prescribed for any reason. If such a case arises where the patient/client treatment plan may include use of narcotics, an appropriate referral will be given to the patient to a local, appropriate provider who will ethically and morally treat with narcotics. _____**initial**

By signing below, I agree that all information is accurate and correct.

Patient/Guardian Signature____________________________________

Printed Name____

Guardian Name_______________________/Relationship_____________

Date/Time_______________________