AccelHealth

CONSENT TO TREATMENT

Please read form in its entirety and ask staff any questions prior to signing:

General Consent: I give permission to AccelHealth, its designated staff, and other medical, dental, mental/behavioral health and social service personnel providing services, case management and counseling under its sponsorship to provide services as indicated by license and/or title including physical, dental and /or mental/behavioral health assessments or examinations, conduct laboratory or other tests, (which may include HIV testing) give injections, medications and other treatment as appropriate and render any other physical, dental or mental health services to the patient identified on this form.

Informed Consent for Telemedicine and/or Telehealth: Telehealth and telemedicine services are health care services delivered by physicians and health professionals to patients located at a different physical location using telecommunications or other information technology. Telecommunications or other information technology may also be used for virtual check-ins, e-visits, initial evaluations, screenings, and pre and post visit communication by AccelHealth staff.

- I understand the same standard of care applies to health care services delivered via telemedicine and/or telehealth as applies to an in-person visit.
- I will not be physically in the same room as my healthcare provider.
- I will be notified of, and consent obtained, for anyone other than my healthcare provider present in the room.
- I understand there are certain hazards and risk connected with all forms of treatment, regardless of the medium used, and my consent is given knowing potential risk using technology, including service e interruptions, interception and technical difficulties.
- If it is determined the telecommunications or information technology is not adequate the visit may be discontinued.
- I have the right to refuse to participate or decide to stop participating in a telemedicine/telehealth visit at any time.
- AccelHealth has no liability or responsibility for the accuracy or completeness of the medical information submitted to them or for any errors in its electronic transmission.
- Information shared using telecommunications may include patient medical records, medical images, medical audio or video files, two-way audio and video, and output data from medical devices. The systems used by the center to transmit and receive this information will incorporate network and software security protocols intended to protect the confidentiality of the patient's identify and information.

Release of medical/dental/mental health information: I hereby give permission for medical, dental and mental/behavioral health information obtained by AccelHealth to be released to other health care providers as is necessary for referral purposes only. I furthermore understand that AccelHealth uses electronic records and these records are shared within staff providing services.

Payment Policy: It is my responsibility to confirm that the physician/dentist/clinician is a covered provider under my insurance plan. I hereby authorize the assignment of benefits (payments) directly to AccelHealth (Cross Timbers Health Clinics, Inc.) for all my insurance claims related to services received. I understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments/deductibles with any managed care contract and non-covered services.

The statement below is for patients who have insurance:

I authorize the release of any medical, dental and/or mental/behavioral health information necessary to process reimbursement for treatment services and request payment of Medicare/Medicaid (or any other third party reimbursement, public or private, for which I may be eligible). FOR MEDICARE/MEDICAID: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. Photocopy shall be valid as an original*. I request that payment of authorized Medicare and/or Medicaid benefits be made on my behalf to AccelHealth (Cross Timbers Health Clinics, Inc.) for any services furnished to me by the providers of this group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature authorizes requests for payment as well as release of any medical information necessary for CMS or the Medicaid payer to pay the claim. I also acknowledge that AccelHealth agrees to accept the charge determination of the Medicare carrier as the full charge and I agree to be responsible only for the deductible, coinsurance, or non-covered services. Coinsurance and deductible amounts are based on the charge determination of the Medicare carrier. The clinic agrees to accept

Medicaid Payments in accordance with Medicaid regulations as payment in full. **Medigap Release**: For Medicare Patients with supplemental Medigap insurance a separate signature is needed. I request Medigap benefits be made on my behalf for services rendered. I authorize release to my Medigap carrier any information needed to determine benefits.

I acknowledge receipt of the following documents:

- WELCOME TO ACCELHEALTH
- PCMH, YOUR MEDICAL HOME
- Patient rights and responsibilities
- HIPAA NOTICE OF PRIVACY PRACTICES
- FINANCIAL POLICY

By your signature below, you certify that this form was fully explained to you and that any questions you have about services have been answered to your satisfaction and documents were received. This informed consent is valid and remains in effect as long as I am a patient for AccelHealth, until I withdraw my consent, or until the center changes its services and ask me to complete a new consent form.

Patient First Name: *

Patient Last Name: *

Signature of Patient, Guarantor or Guardian (Please Type) *

Date: *