General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, therapeutic or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical or therapeutic examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical or therapeutic examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

The privacy of all communications between you and your treatment provider is protected by law. Information can only be released to others with your written permission, with only a few exceptions. In some legal proceedings, a judge may order the testimony of your provider if he/she determines that the issues demand it. If your provider believes that a child, elderly, or disabled person is being abused or has been abused, they may be required to make a report to the appropriate state agency. If your provider believes that you are an imminent risk to the safety of yourself or others, they may be required to notify the potential victim(s) and local law enforcement to take protective actions. Your provider will attempt to fully discuss these situations with you before taking action.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature _____ Date _____Time _____

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If patient is a minor or unable to sign, please complete the following:

Signature_____ Relationship _____ Date_____

Office Staff Signature _____ Date_____ Time _____

CONSENT FOR TELEHEALTH SERVICES

Patient's Name: _____ **DOB**:_____

x I understand that my healthcare provider has recommended to me that I engage in a telehealth appointment.

x My healthcare provider has explained to me how telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/healthcare provider visit and I will not be in the same room as my healthcare provider.

x I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time

x I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my healthcare provider and specialty healthcare provider to operate the equipment. The above-mentioned people will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.

x I have had the alternatives to a telehealth appointment explained to me, and in choosing to participate in a telehealth appointment, I understand that some parts of the exam involving physical tests may be omitted due to the simple fact that I am not in the provider office.

x I understand that because of my choosing telehealth, there may be a delay in diagnosis, inexact diagnosis, or ancillary tests that may be ordered to assist diagnosis, but that otherwise may not have been ordered had I been treated in person in the provider office.

x I understand that my insurance may not encompass telehealth services. In cases where my insurance plan does not cover any or all expenses which have been incurred, I will be personally liable to cover these expenses.

x In an emergency, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.

x I have read this document carefully and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

Patient Signature _____ Date _____Time _____

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If patient is a minor or unable to sign, please complete the following:

Signature_____ Relationship _____ Date_____

APTIVA HEALTH

Office Staff Signature _____ Date_____ Time _____

PATIENT INFORMATION

First Name: _____ M.I. ___ Last Name: _____ DOB: _____

Address: _____City: _____State: _____ Zip: _____

Cell:_____ Email:_____ SS#: _____

Sex: [ ] Male [ ] Female Emergency Contact_____ Phone: _____

Date of Injury: _____ Is injury related to: ☐ MVA ☐ Work ☐ Fall ☐ Sports ☐ Health

Location of Pain/Injury: _____

AUTO/WORK INSURANCE INFORMATION

Did you have auto insurance at time of injury (if MVA): ☐ Yes ☐ No Have you filed a claim? ☐ Yes ☐ No

Auto/Work Insurance Co: _____ Are you the policy holder? ☐ Yes ☐ No

Claim Number: _____ Adjuster: _____

Adjuster's Phone Number: _____ Extension: _____

By providing this information you understand that your auto insurance provides personal injury protection (PIP) benefits as part of your auto insurance policy. Your auto insurance will be billed for any healthcare provided to you related to a motor vehicle accident. You understand that your auto insurance is billed regardless if you were at-fault for the motor vehicle collision (this is why Kentucky is called a "no fault" state).

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ Policy holder name: _____

ID#: _____ Group#:_____

Secondary Insurance: _____ Policy holder name: _____

ID#: _____ Group#:_____

Do you have Medicare, Medicare Advantage or a Supplemental Medicare plan? ☐ Yes ☐ No

I understand that health and insurance policies are an arrangement between the insurance carrier and myself: I authorize payment from my insurance carrier directly to this office with the understanding that all money will be credited to my account upon receipt. I state that all the above information is true and accurate.

Patient Signature: _____ Date: _____

APTIVA HEALTH

********** FOR INTERNAL OFFICE USE ONLY **********

ER Records requested on: _____ **ER Records received on:** _____

Has patient met deductible? [ ] Yes [ ] No -- Specialist Co-Pay: _____ Generalist Co-Pay: _____

Patient Name:_____ **DOB:**_____

Reason for appointment: _____

PAST MEDICAL HISTORY

PCP Name: _____ PCP Phone: _____

No significant past medical history [ ] (*skip to Social History if none*)

Have you been diagnosed with or had any of the following?

	Yes	No		Yes	No
Arthritis			HIV		
Asthma			High Blood Pressure		
Cancer			Migraine		
COPD			Seizure		
Coronary Artery Disease			Anxiety		
Diabetes Mellitus			Bipolar Disorder		
GERD/Reflux			Depression		
Hepatitis			Other Mental Health		

Any other significant history? _____

Any metal implants (i.e. joints) or implanted devices (defibrillators, artificial lens)? _____

Are you being treated with pain medication or in pain management? ☐ Yes ☐ No

SOCIAL HISTORY

Are you Pregnant? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No If yes, how many packs a day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how often _____

Do you use illegal drugs? ☐ Yes ☐ No Have you used illegal drugs in the past? ____Yes _____No

FAMILY HISTORY

____ None or noncontributory

____Yes Please List: _____

Additional details: _____

SURGICAL HISTORY

Type of surgery?	Year

Patient Name:_____ **DOB:**_____

MEDICATIONS

Are you allergic to medication? ____Yes ____No

If yes, list: _____

Please list all medication, vitamins, or supplements that you are currently taking:

Name	Dose	Frequency	Condition

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions.

I, _____, hereby acknowledge that Aptiva Health has made available a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how l can access this information. I understand that if I have questions or complaints, I may contact:

Office Manager – 1-844-999-DOCS (3627)

I also understand that I am entitled to receive updates upon request if Aptiva Health amends or changes its Notice of Privacy Practices in a material way.

Patient's name if not signed by patient: _____

Authorized Signor if patient is a minor: _____ Date: _____

THIS SECTION IS TO BE COMPLETED BY APTIVA HEALTH IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.

[ ] Other (specifiy):_____

Name and title of employee: _____ Date: _____

FINANCIAL AGREEMENT AND AUTHORIZATIONS

I, _____, do hereby authorize Aptiva Health, LLC (hereinafter "Aptiva"). to furnish my legal representative, with a full report of my examination, diagnosis, treatment, prognosis, and complete patient file.

I fully understand and agree that I am directly and wholly responsible to Aptiva for all medical bills submitted for services rendered to me, and that my obligation for payment to Aptiva is absolute and continuing until any outstanding charges owed to Aptiva are satisfied in full.

I agree that if I, or anyone acting on my behalf, receives funds from any third person or insurance company, whether by settlement, judgment, verdict, award, or claim payment or reimbursement, or otherwise, as payment, reimbursement, or compensation for the medical bills for services rendered to me, that Aptiva shall be entitled to payment from any such funds for the payment for said medical bills. I hereby authorize and direct my attorney and/or legal representative or any person receiving said funds on my behalf to pay directly such sums as may be due and owing to Aptiva from any such funds. I further authorize and direct my attorney and/or legal representative or any person receiving said funds on my behalf to withhold such sums from any settlement,

judgment, award, claim reimbursement and/or verdict as may be necessary to satisfy any outstanding amount owed to Aptiva for my medical treatment and care.

Authorization to Release/Obtain Information: By signing this authorization you are deemed to understand and permit Aptiva Health, or any of its affiliates, to release any information stated herein and any private or HIPAA protected information to my attorney, legal representative, insurance company, reparation obligor or any thirdparty investigator. Release of information may be conducted by mail, email, facsimile, telephone, or other electronic means. Aptiva, or any of its affiliates, may also interrogate your medication history, prescribed or unprescribed via KASPER or other means. Aptiva, or any of its affiliates, may also release information including the diagnosis, records, examination rendered, and claims information, between Aptiva and/or its affiliates.

Medicare: I hereby request that payment of authorized medical benefits be made to Aptiva, for any services furnished to me by any of those medical facilities. I authorize the release of any medical information about me, from any holder of said information, to the Health Care Financing Administration and its agents. That release encompasses any information needed to determine benefits payable for related services provided by Aptiva.

Commercial Insurance: I hereby authorize Aptiva to submit claims to my insurance carrier or its intermediaries for any and all covered services rendered and further DIRECT MY INSURANCE CARRIER AND ITS INTERMEDIARIES TO ISSUE PAYMENT BY CHECK DIRECTLY TO THE CHARGING FACILITY. I further authorize Aptiva to take any and all necessary steps, including but not limited to appealing denied claims and submitting any complaint or grievance on my behalf, in order to obtain payment from my insurance carrier.

I understand that I am wholly financially responsible for any balance not covered by my insurance carrier(s).

Patient Signature: _____ Date: _____

Medical Information Release Form (HIPAA Release Form)

Patient Name:_____ **DOB:**_____

Release of Information

[x] I authorize the release of information including the diagnosis, records, examination rendered, and claims information. This information may be released to:

____ Spouse _____

____ Child(ren) _____

_x__ Other __Aptiva Health_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number:

_____ If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call.

☐ Other: _____

Patient Signature _____ Date _____Time _____

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If patient is a minor or unable to sign, please complete the following:

Signature_____ Relationship _____ Date_____

Office Staff Signature _____ Date_____ Time _____

CANCELLATION / NO SHOW POLICY

1. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving the treatment they need. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
2. We understand that delays can happen however we must try and keep all patients on time to ensure proper care is received. **If you are 15 minutes late for your scheduled appointment, you may be asked to reschedule.**
3. When you need to cancel, or reschedule a visit we expect you to contact our office no later than 24 hours before your scheduled visit. This allows us a reasonable amount of time to determine

the most appropriate way to reschedule your care. This courtesy also provides us the opportunity to schedule other patients in the now vacant appointment slot. If it is less than 24 hours before your appointment, and you will not be able to attend your appointment, please give us the courtesy of a phone call.

4. **Patients with 3 or more no shows or cancellations may be subject to discharge.**

Patient Signature _____ Date _____Time _____

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If patient is a minor or unable to sign, please complete the following:

Signature_____ Relationship _____ Date_____

Office Staff Signature _____ Date_____ Time _____