Consent for Treatment, Health Information Exchange and Privacy Form

Account No:_____ Patient Name: _____DOB:_____

CONSENT FOR TREATMENT:

I consent to allow Affinia Healthcare to use and disclose my protected health information in order to carry out medical treatment, payment and healthcare operations. I authorize Affinia Healthcare to provide for all medical, dental, behavioral and/or surgical treatment. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.

CONSENT FOR TELEHEALTH AND USE OF ELECTRONIC MEDIA:

Telehealth and electronic media/communication may be part of care at Affinia Healthcare. I consent to participate in telehealth with Affinia Healthcare as part of my treatment. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a health care professional employed or contracted by or affiliated with Affinia Healthcare and may include the evaluation, diagnosis, consultation, and treatment of a patient's medical or health condition using advanced telecommunication technology.

I understand that Telehealth Services may include interactive audio, video or other electronic media and that there are both risks and benefits to being treated via Telehealth. I further understand that Telehealth Services may be limited or unavailable because of technological or equipment failures, incomplete or inaccurate data to perform the Telehealth Services, or distortions of images or other information from electronic transmissions. Covered healthcare providers will not be subject to penalties for violations of the HIPAA Privacy, Security, and Breach Notification Rules that occur in the good faith provision of telehealth during the COVID-19 nationwide public health emergency. I have the right to decline telehealth services.

PAYMENT:

I request that payment of authorized insurance carriers be made on my behalf to Affinia Healthcare for any services furnished to me. I understand that there is no guarantee of reimbursement or payment from any insurance company or third-party payor. I accept financial responsibility for all charges for medical care provided not otherwise covered by insurance or third-party payor, with the understanding that I may be eligible for a sliding fee discount after providing appropriate income and family-size documentation.

HEALTHCARE OPERATIONS:

I understand that Affinia Healthcare may use or disclose, as needed, my protected health information in order to support the business activities of the practice. These activities include, but are not limited to quality assessment activities, scribe documentation, employee review activities, training health care professionals, and research. I have the right to decline a student learner in my visit without negative consequences to my care.

HEALTH INFORMATION EXCHANGE:

I understand and agree that my health information may be stored in or exchanged through one or more electronic health information exchanges through which health care professionals and facilities and others involved in my care may view and obtain my information. I also understand and agree that, once my health information is exchanged in that way, it may be added into other treating providers' medical records, and may be aggregated with the health information of others and used or disclosed to conduct data analysis, or for any other lawful purpose.

I understand that this HIE Consent applies to information generated prior to the date of this HIE Consent and during any subsequent visit while this Consent is in effect. This HIE Consent is effective on the date of my signature (or the signature of my authorized representative) below. The Consent for Release of Sensitive Information expires with respect to information about mental health and developmental disability services [25] years after the signature date on this HIE Consent. I may revoke this HIE Consent in writing, at any time; provided, however, that such revocation will not apply to any uses or sharing of my health information that occurred prior to the date the written revocation was received. If I do not respond my information will be shared.

Acknowledgement of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices. This Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. I am aware that the Notice may be changed at any time. I was given the opportunity to review the Notice and ask questions regarding my privacy rights. I understand that by law, Affinia Healthcare may use or disclose specific information without authorization. Those specific reasons are listed in the Notice. I further understand that my medical information is protected under HIPAA for privacy and confidentiality and cannot be released without my written consent; except in the instance stated above and for continuity of care purposes. By signing this form, I am authorizing Affinia Healthcare's use and disclosure of my protected health information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing.

Patient Signature Date

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Signature of Parent or Patient's Representative (if applicable) Date

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(Rev 04/22)