Grace Health & Wellness Clinic
1601 Main Street, STE 404
Richmond, TX 77469
(346) 444-3653

Consent for Treatment/Financial & Office Policy Acknowledgements

Grace Health & Wellness Clinic

We are committed to providing you with quality and affordable health care. We believe that stating our expectations regarding financial & office policies helps us concentrate on our mission of providing excellent care.

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Grace Health & Wellness Clinic, here forth Grace HWC, its medical practices and providers including physicians, Advanced Practice Registered Nurses (APRN), technicians, nurses, and other qualified personnel, including appropriately supervised students to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures.

TREATMENT OF MINOR CHILDREN: I understand patients who are minors must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at time of service(s) regardless of court-ordered responsibility.

PHOTOGRAPHY/VIDEO: I acknowledge that my photograph may be taken for chart identification and documentation purposes for my electronic health record and is the property of Grace HWC unless I withdraw my consent in writing. I consent to videotaping for a telehealth appointment for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations. I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the Grace HWC provider of service(s) furnished to me. I authorize Grace HWC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Grace HWC. I hereby authorize that photocopies of this form are to be valid as the original.

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DEDUCTIBLES: Because more insurance companies are issuing policies with very high deductibles, we will need to collect deductibles that have not been met at the time of service. It is your responsibility to call your insurance company prior to being seen to see if you have met your deductible. Grace HWC has formulated a fee amount as close as possible to the allowable amount that will be covered by your insurance company. Anything overpaid or underpaid will either be credited or billed to you accordingly. If you do not call your insurance company prior to being seen, we will assume that you have not met your deductible and payment of the allowable amount is due at the time of service.

NON-COVERED SERVICES: It is virtually impossible for us to have knowledge of what services each insurance plan covers. Knowing your insurance benefits is your responsibility. Any questions you may have regarding those benefits or dispute of any services not covered should be directed to your insurance company.

SELF-PAY PATIENTS: I understand if I do not have active coverage or choose not to utilize my insurance benefits, I am responsible for all charges that occurred at time of service.

PAYMENT GUARANTEE: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through Grace HWC medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a Grace HWC billing statement whether it is an interim or final bill. If I fail to make full payment or fail to comply with other payment arrangements made with Grace HWC's approval, I understand that appropriate collection measures may be initiated. I understand and agree that my payments will be processed by Global Pay, a third-party business associate. I hereby consent my payment information to be collected and stored securely by Global Pay.

RESTRICTED SERVICE: I understand that all account balances must be in good standing prior to receiving additional services and I will contact Grace HWC's staff if I am unable to pay any balance. Past Due Accounts of 60 days or longer may be turned over to a third-party for collection, along with collection costs, attorneys' fees and court fees. I also understand I may be discharged from the practice.

ADDITIONAL SERVICE CHARGES: Checks may be processed at time of service, if there are insufficient funds available, I understand I will be responsible for providing an alternate payment for the account amount, plus a $35.00 NSF fee.

ELECTRONIC HEALTH RECORD: I understand the following: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. Grace HWC has a system-wide electronic medical record that is available to

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caregivers on a “need to know” basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems are maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated Grace HWC and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. Grace HWC can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record. I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE). Grace HWC will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records.

If I have provided my e-mail address, I am requesting the ability to access my medical information through the Grace Health & Wellness Clinic online Patient Portal.

ELECTRONIC PRESCRIBING: I understand that Grace HWC medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my Grace HWC providers and my pharmacy. I have been informed and understand that Grace HWC providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my Grace HWC providers to see this health information. We ask that you allow 3 business days to process all refill requests.

PRIOR AUTHORIZATONS: Grace HWC will assist in obtaining referrals and prior authorizations. I understand that these may take up to 3 business days to complete and may require my assistance in obtaining from my insurance company.

CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES: I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that “virtual health” or “telemedicine services” includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand that the potential

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benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

CANCELLED APPOINTMENTS: I understand that cancelled appointments negatively impact my provider's ability to deliver excellent care. A "no show" cancelled appointment is defined as any appointment not cancelled 24 hours in advance. There will be a $50 charge for all "no show" visits.

IMMUNIZATION REGISTRY: I understand that Grace HWC participates in the Texas Dept. of Health's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws. I do hereby grant permission for Grace HWC to send or fax childhood immunization records to schools, upon request.

CELL PHONES: I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from Grace HWC, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that all Grace HWC medical practices and offices provide no facilities for safekeeping of valuables. I do hereby release Grace HWC from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to a Grace HWC medical practice, office or facility.

NOTICE OF PRIVACY PRACTICES: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of Grace HWC's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my

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protected health information generated during hospitalization and outpatient treatment at any Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested. The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of it. I hereby agree to all terms and conditions set forth above.

_____

Signature of Patient or Parent/Legal Guardian/Authorized Representative

_____

Relationship to Patient if Applicable

_____

Date