VerityMD Inc. | Neurology Clinic
5841 Jameson Court, Suite 2, Carmichael, CA 95608
(916) 500-4989 | (916) 244-3875
www.veritymd.com

CONSENT TO TREAT – HEALTH CARE AGREEMENT

I hereby consent to the **evaluation, management, diagnostic procedures, testing, and treatment** as directed by the physicians, nurse practitioners (NPs), physician assistants (PAs), associates, or designees of **VerityMD Inc. | Neurology Clinic**.

I understand that **VerityMD Inc.** may have teaching affiliations, and I may receive care from **medical students, advanced practice clinician (APC) students, physician assistant students, and medical assistant (MA) students** under appropriate supervision. I may request and receive information regarding the credentials of any healthcare provider involved in my care.

I understand that this **Consent to Treat** remains valid for each visit to VerityMD Inc. until I revoke it **in writing**.

Use & Disclosure of Health Information

I acknowledge that **VerityMD Inc.** may release my **protected health information (PHI)** as necessary for **treatment, payment, and healthcare operations**, in accordance with HIPAA regulations.

PHI may include, but is not limited to:

- Medical history, diagnoses, treatment plans, and prognoses
- Mental health conditions (excluding psychotherapy notes)
- Use of alcohol, drugs, or medications
- Laboratory results, including **HIV testing** or **AIDS diagnoses**

I consent to the use of **electronic health information exchange systems** for the transmission and retrieval of my medical records, prescriptions, lab results, and other healthcare data. I understand that I may **opt out** of such electronic exchanges upon request.

NEUROLOGY CLINIC
VERITYMD
HOPE, HEAL, ADVANCE

I authorize my **primary care provider, referring physician, and other healthcare providers** to share my medical information with **VerityMD Inc.** as needed for my care.

I also authorize **VerityMD Inc.'s medical billing service** to release the necessary medical information to process my insurance claims and access my **medication history** for billing and treatment purposes.

Photography & Digital Imaging Consent

I consent to the use of **photographs/digital images** for:

- Treatment planning and education
- Identity verification
- Payment processing

I understand that **VerityMD Inc.** retains ownership rights to these images, but I may request to view or obtain copies.

Exposure to Bloodborne Pathogens

As permitted by **California law**, I consent that if a **healthcare worker is exposed** to my blood or bodily fluids, my blood may be tested for **HIV antibodies and other communicable diseases** at no cost to me.

Notice of Privacy Practices

I acknowledge that I have **read and received** a copy of the **VerityMD Inc. Notice of Privacy Practices**, which details how my **protected health information** may be used and disclosed.

I may request a copy of my medical records at any time.

Authorized Individuals for Health Information Disclosure

I authorize **VerityMD Inc.** to discuss my medical information with the following individuals:

NEUROLOGY CLINIC
VERITYMD
HOPE, HEAL, ADVANCE

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that it is my responsibility to update this list if circumstances change.

I have **read, understood, and agreed** to the terms outlined above. I acknowledge that these terms may be amended from time to time by **VerityMD Inc. | Neurology Clinic**.

Patient Name: _____
Signature: _____ Date: _____

If signed by someone other than the patient (e.g., legal guardian):
Name: _____
Relationship to Patient: _____