My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Welcome to My Whole Health Solutions!

We are truly grateful that you have chosen us for your primary and psychiatric care. Your health and well-being are our utmost priorities, and we are dedicated to providing you with thorough and compassionate support.
Your initial appointment will be an opportunity for us to learn more about you and collect important information. During this visit, you will meet your healthcare provider and care team, discuss your medical history, and grant access to your previous records. Together with your provider, you will create a personalized plan to meet your health and wellness needs, including scheduling any necessary follow-up visits.
We kindly request that you complete the following forms. This will help us offer quality care and services specifically tailored to your requirements. Please retain this first page for your reference, and feel free to reach out if you have any questions.

Thank you,
The My Whole Health Solutions Care Team

Clinic Hours
Please note that we do not offer emergency care after hours.
Our operating hours are Monday through Friday, from 9:00 AM to 5:00 PM.
For inquiries, you may reach us via email at: ClinicalStaff@MyWholeHealthSolutions.com.

Medical Emergencies and After-Hours Coverage
In the event of a medical emergency requiring immediate assistance, please call 9-1-1.
For inquiries related to scheduling, billing, or other services, kindly reach out to us during our normal business hours.

CONSENT FORMS INCLUDED BELOW:
As indicated in the registration forms, we are providing you herein with detailed information on the consent forms listed below that are to be signed at registration:

- Consent to Treat Primary Care **and/or** Psychiatric Care
- Intake Forms
- Patient Rights and Responsibilities
- Notice of Privacy Practices
- Health Information Exchange
- Medical Record Release Form
- Chronic Care Management Consent
- Telemedicine Consent
- Notice of advance directives

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Consent to Treat: Primary Care

Medical care at with My Whole Health Solutions provides a comprehensive range of services designed to meet the diverse healthcare needs of patients of all ages, regardless of gender, race, creed, national origin, or disability. The objectives of our medical care include:

Comprehensive Evaluation and Ongoing Care
- We provide thorough assessments and routine care to address the unique health needs of older adults. This includes evaluation and management of chronic conditions such as hypertension, diabetes, arthritis, heart disease, and other age-related health concerns.

Medication Management
- We review and manage all medications to ensure safety, reduce the risk of drug interactions, and adjust prescriptions based on individual needs, tolerance, and effectiveness.

Preventive Health Services
- We offer screenings, vaccinations, lab testing, and age-appropriate preventive care to support overall health and detect potential concerns early.

Chronic Disease Monitoring and Support
- We develop personalized care plans to manage long-term conditions, help prevent complications, and maintain stability in day-to-day health.

Care Coordination and Referrals
- We collaborate with specialists, home health providers, and community services to ensure each patient receives comprehensive, well-coordinated care.

Health Education and Lifestyle Counseling
- We provide guidance on nutrition, exercise, and other healthy habits tailored to the needs and goals of each older adult.

I acknowledge my right to make informed decisions regarding my medical care, understanding that all procedures, treatments, and health education sessions are voluntary. My healthcare provider will furnish me with pertinent information regarding any recommended treatments or procedures. If I am unable to adhere to the recommended medical plan, I will communicate this to my healthcare team.

I am aware that I can still access other services at this clinic, even if I choose to decline a specific service. I retain the right to change my mind about the services I am currently receiving, and I can request the cessation of any treatment or procedure at any time.

I confirm that I have read the Authorization for Treatment and Patient Rights and Responsibilities, and I am aware that I can request copies of these documents from My Whole Health Solutions.

I consent to the use of a HIPAA-compliant AI scribe during my session. I understand that there is no recording of the session and that all information is stored only for a short period on a secure, HIPAA-compliant platform solely for the purpose of accurately documenting my visit.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Consent to Treat: Psychiatric Care

My Whole Health Solutions provides specialized geriatric psychiatric care designed to address the complex mental health needs of older adults. Our comprehensive services include detailed psychiatric evaluations, cognitive assessments, psychotherapy, medication management, and support for both patients and their caregivers. Our objectives in providing geriatric psychiatric care are to:

Evaluate and Treat Psychiatric Conditions:

- Conduct thorough evaluations and diagnostic assessments to identify mental health disorders.
- Utilize a combination of clinical interviews, standardized cognitive tests, and behavioral assessments to form a precise diagnosis.

Gather Essential Information for Accurate Diagnosis

- Collect comprehensive medical, psychiatric, and psychosocial histories to guide treatment planning tailored to the unique challenges faced by older adults.

Minimize Cognitive and Emotional Decline:

- Implement individualized treatment plans designed to slow the progression of cognitive impairments and alleviate symptoms of psychiatric disorders.
- Provide both pharmacological and non-pharmacological interventions, such as psychotherapy and supportive counseling, to optimize mental health and overall well-being.

Enhance Quality of Life and Functional Independence:

- Support patients in achieving and maintaining their highest level of emotional, cognitive, and social functioning within their capabilities.
- Offer caregiver education and support to facilitate a nurturing environment that promotes recovery and sustains independence.

I acknowledge my right to make informed decisions regarding my medical care, understanding that all procedures, treatments, and health education sessions are voluntary. My healthcare provider will furnish me with pertinent information regarding any recommended treatments or procedures. If I am unable to adhere to the recommended medical plan, I will communicate this to my healthcare team.

I am aware that I can still access other services at this clinic, even if I choose to decline a specific service. I retain the right to change my mind about the services I am currently receiving, and I can request the cessation of any treatment or procedure at any time.

I confirm that I have read the Authorization for Treatment and Patient Rights and Responsibilities, and I am aware that I can request copies of these documents from My Whole Health Solutions.

I consent to the use of a HIPAA-compliant AI scribe during my session. I understand that there is no recording of the session and that all information is stored only for a short period on a secure, HIPAA-compliant platform solely for the purpose of accurately documenting my visit.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Patient Intake Form

Patient Demographics			
Name: Address:	DOB:	Date:	
City:			
Email:		State:	Zip:
Emergency Contact:	Cell #:	Home #:	
Relationship:		Phone #:	
Marital Status:			
ReferralSource:	Gender:	Ethnicity:	
☐ Google ☐ Facebook ☐ Friend ☐ Radio ☐ Doctor ☐ Other			
Primary Care Provider:		Phone #:	

Medications

List all known prescriptions, over the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. *Attach list if more room is needed.*

Medication	Dose	Frequency	Prescribed By

Surgeries/Hospitalizations

Type of Surgery / Hospitalization	Date

Medical Information

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List any vaccines you've had in the last year:

Allergies:

Medical History

Please check any condition you currently have OR have ever had in the past (include childhood illnesses).

- ☐ None
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ BloodClot
- ☐ Anemia
- ☐ Depression
- ☐ Osteoporosis
- ☐ PinsorMetalImplants
- ☐ Arthritis
- ☐ Epilepsy
- ☐ COPD
- ☐ LowLibido
- ☐ LowTestosterone
- ☐ DecreasedHormoneLevels
- ☐ Anxiety
- ☐ Gout
- ☐ Seizures
- ☐ Hepatitis
- ☐ Stroke
- ☐ Concussion
- ☐ STD
- ☐ Hernia
- ☐ VisualDysfunction
- ☐ NeurologicDisorder
- ☐ SinusProblems
- ☐ StomachProblems
- ☐ LowBloodPressure
- ☐ Fibromyalgia
- ☐ Pacemaker
- ☐ HeartProblem
- ☐ InfectiousDisease
- ☐ Alcoholism
- ☐ SleepProblems
- ☐ LegSwelling
- ☐ BreathingProblems
- ☐ Migraines/Headaches
- ☐ ThyroidTrouble
- ☐ Lupus
- ☐ Ulcers
- ☐ HighBloodPressure

Additional Information of family history and/or other illnesses (Thyroid Disease, Cancer, etc.,):

Have you experienced any of these symptoms recently? (Check all that apply)

- ☐ ChestPain
- ☐ PainwithMeals
- ☐ Nausea/Vomiting
- ☐ PoorBalance/Falls
- ☐ DifficultySwallowing
- ☐ UnusualPain w/Menstruation
- ☐ UnexplainedWeight Gain/Loss
- ☐ Self-Injury
- ☐ Dizziness
- ☐ Vision Changes
- ☐ Memory Problems
- ☐ Unusual Weakness
- ☐ Shortness of Breath
- ☐ Change in Bowel Habits/Control
- ☐ Change in Bladder Habits/Control
- ☐ Suicidal Ideation
- ☐ Fever/Chills/Sweats
- ☐ DifficultySpeaking
- ☐ Numbness/Tingling
- ☐ ChangeinAppetite
- ☐ Confusion/BrainFog
- ☐ IncreasedPainatNight/Rest
- ☐ Other:

Women's Health History

Pregnancy Complications:

Date of Last Menstrual Cycle: | Possibly Pregnant: ☐ Yes ☐ No

Number of Pregnancies: | Number of Live Births: | Age of Menopause:

Lifestyle

Tobacco Use: ☐ Yes ☐ No

If yes, packs per day: Number of Years:
Have you ever stopped? ☐ Yes ☐ No If so, for how long?

Alcohol Use: ☐ Yes ☐ No

If yes, drinks per day/week: ☐ Beer ☐ Wine ☐ Liquor
Have you been told your drinking is a concern? ☐ Yes ☐ No

Drug Use: ☐ Yes ☐ No

Marijuana: ☐ Yes ☐ No
Ever used needles: ☐ Yes ☐ No

Notes:

Diet: ☐ Balanced ☐ Vegetarian ☐ Diabetic ☐ Low Carb ☐ Low Fat ☐ Low Salt

How would you rate your diet? ☐ Good ☐ Fair ☐ Poor

Would you like nutritionala dvice? ☐ Yes ☐ No

Exercise: Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise?

Duration:

Frequency:

Sleep: How many hours, on average do you sleep a night?

Trouble falling asleep? ☐ Yes ☐ No

Troubles taying asleep? ☐ Yes ☐ No

Additional information or concerns you would like to address with us:

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

_____ _____ _____

Signature of Patient or Representative | Printed Name of Patient | Date

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Patient Bill of Rights

- Respect and Dignity: You have the right to be treated with respect, courtesy, and consideration at all times, regardless of your age, race, gender, religion, national origin, sexual orientation, or any other characteristic.
- Privacy and Confidentiality: Your medical information will be kept confidential and will not be disclosed without your written consent, except as required by law. You have the right to review and request a copy of your medical records.
- Informed Consent: You have the right to be informed about your medical condition, treatment options, potential risks, and expected outcomes. You can make decisions about your care after understanding all relevant information.
- Quality of Care: You have the right to receive the highest quality of medical care that is available, provided by competent and qualified healthcare professionals.
- Access to Information: You have the right to access information about your diagnosis, treatment plan, and the names and credentials of your healthcare providers.
- Participation in Care Decisions: You have the right to actively participate in your healthcare decisions. This includes the right to refuse treatment, except as otherwise required by law.
- Pain Management: You have the right to appropriate pain management and the opportunity to discuss and receive information about pain relief options.
- Consent for Research and Clinical Trials: If applicable, you have the right to be informed about and provide informed consent for participation in any research or clinical trials involving your care.
- Access to Emergency Care: You have the right to access emergency medical care when necessary, regardless of your ability to pay or insurance status.
- Non-Discrimination: You have the right to receive care without discrimination, and we will not discriminate against you in the provision of healthcare services.
- Complaints and Grievances: You have the right to voice complaints or concerns about your care without fear of retaliation. We are committed to addressing your concerns promptly and fairly.
- Advance Directives: You have the right to create and provide advance directives for your medical care, and we will respect your wishes in accordance with the law.
- Cultural and Religious Beliefs: Your cultural and religious beliefs will be respected to the extent possible in the provision of care.
- Accessibility: We will strive to make our facilities and services accessible to individuals with disabilities in accordance with applicable laws and regulations.
- Financial Transparency: You have the right to receive an explanation of your bill for services, and we will provide information on any charges that may not be covered by insurance.

By receiving care at My Whole Health Solutions, you acknowledge and accept these rights. We are dedicated to upholding these principles and ensuring that you receive the highest standard of care and respect during your medical treatment.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date

COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Patient Responsibilities

- The patient (or their parent or legally designated representative) is responsible for providing, to the best of their knowledge, accurate and complete information regarding their current complaints, past illnesses, hospitalizations, medications, and other relevant health matters.
- The patient (or their parent or legally designated representative) must report any unexpected changes in their condition to the responsible practitioner. It is essential for the patient to communicate whether they fully understand the proposed course of action and the expectations placed upon them.
- The patient (or their parent or legally designated representative) is responsible for adhering to the treatment plan recommended by the primary practitioner overseeing their care.
- Should the patient (or their parent or legally designated representative) refuse treatment or fail to follow the practitioner's instructions, they are accountable for the consequences of their actions.
- If the patient is unable to comply with the treatment regimen, they must inform the primary practitioner responsible for their care.
- The patient (or their parent or legally designated representative) is also responsible for following the rules and regulations of the health center that pertain to patient care and conduct.
- The patient (or their parent or legally designated representative) should demonstrate consideration for the rights of other patients and personnel.
- The patient is responsible for respecting the property of others and the facilities of the health clinic.
- A patient's health is influenced not only by the care they receive but also by the decisions they make in their daily lives. They must acknowledge the impact of their lifestyle choices on their overall well-being.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date

COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Notice of Privacy Practices

This Notice of Privacy Practices outlines how your medical information may be used and disclosed, and describes your rights under the Health Insurance Portability and Accountability Act (HIPAA) and other relevant laws. "Protected health information" (PHI) includes your identifying demographic details and pertains to your past, present, or future physical or mental health conditions and healthcare services. We understand the personal nature of your medical information and are committed to protecting it. The records we maintain about your care and services are crucial for delivering high-quality care and meeting legal requirements. Please review this notice carefully.

Uses and Disclosures of Health Information Treatment: Your health information may be used to provide, coordinate, or manage your medical care, including sharing with healthcare professionals involved in your treatment. Payment: We may use and disclose your health information to bill and collect payments, including communicating with insurance companies or third-party payers. Health Care Operations: We may utilize your health information for our daily operational and management needs, such as budgeting, financial activities, complying with legal requirements, and mandated government reporting. Required by Law: We may disclose your health information when legally required, such as reporting specific diseases to public health authorities. Legal Proceedings: We may disclose your health information in response to court orders, subpoenas, or other legal processes. Worker's Compensation: Your health information may be disclosed to comply with worker's compensation laws. Public Health Reporting: As mandated by law, we may disclose your information to public health agencies, for instance, reporting certain communicable diseases. Appointment Reminders: We may contact you with reminders for upcoming appointments, tests, or follow-up care.

Other Uses and Disclosures Requiring Your Authorization: Any use or disclosure of your health information not mentioned above requires your explicit written authorization. If you later revoke your authorization in writing, it will not affect disclosures made prior to receiving your revocation.

Our Responsibilities: We are legally required to protect the confidentiality of your PHI, provide you with this privacy notice, and follow the policies and procedures described herein. We may revise these policies and procedures in compliance with applicable laws, and such changes will apply to all PHI we maintain. Updated notices will be available at our facility upon request. Federal regulations require written requests for inspecting or copying PHI.

Your Rights Regarding Your Health Information: Right to Request Amendments: You may request corrections or amendments if you believe your health information is incorrect or incomplete. Right to an Accounting of Disclosures: You may request a list of disclosures we have made of your health information. Right to Request Restrictions: You may request restrictions on how your health information is used or disclosed. Right to Request Confidential Communications: You may specify how or where you wish to be contacted. Right to a Paper Copy: You may request a paper copy of this Notice of Privacy Practices.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Medical Records Release

Patient Information			
Name (First, Middle, Last):			DOB:
Address: Phone #:	City:	State:	Zip:
	Email:	Medical Record #:	

Records Request Details

Entity Releasing Records			
Entity Name: Address: Phone		Contact Name:	
#:	City:	State:	Zip:
Entity Receiving Records	Fax #:	Email:	
Entity Name: Address: Phone			
#:		Contact Name:	
	City:	State:	Zip:
	Fax #:	Email:	

Information Release Details

Effective Time Period: Purpose of Release: Type of

Records Being Released (check all that apply):

- ☐ RadiologyReports
- ☐ Film/CDImaging
- ☐ ClinicalNotes
- ☐ NursingNotes
- ☐ History&Physical
- ☐ ProvidersOrders
- ☐ Consultations
- ☐ Other:
- ☐ AllMedicalRecords
- ☐ UrgentCareNotes
- ☐ OperativeNotes
- ☐ DischargeSummaries
- ☐ LaboratoryReports
- ☐ PatientBillingRecords
- ☐ EmergencyRoomNotes
- ☐ ProgressNotes

Release of Sensitive Medical Info (check all that apply):

- ☐ Mental Health/Psychiatric Treatment
- ☐ Genetic Testing Information
- ☐ Alcohol or Substance Abuse Treatment
- ☐ STD/HIV/AIDS Treatment(s) or test(s)
- ☐ Additional Info:

Formate:

- ☐ Email Address noted above, where permitted
- ☐ CD
- ☐ Paper copy
- ☐ Other:

Delivery Method:

- ☐ US Mail
- ☐ Pick-up
- ☐ Fax
- ☐ Email
- ☐ Overnight/Express
- ☐ Certified Other:
- ☐

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Health Information Exchange (HIE) Consent

At My Whole Health Solutions we are committed to providing you with the highest quality of care. To enhance the coordination of your healthcare and ensure that your medical information is readily accessible to authorized healthcare providers when needed, we participate in a Health Information Exchange (HIE) network.

The HIE network allows us to securely share and receive electronic health records (EHRs) with other healthcare facilities, including hospitals, specialists, and primary care providers. This exchange of information is crucial for ensuring that you receive the most comprehensive and timely care possible, especially in emergency situations. To participate in the HIE network, we require your informed consent. By signing below, you acknowledge that you have read and understood the following:

Purpose of the HIE: The primary purpose of the HIE is to improve the quality and coordination of your healthcare by making your medical records available to authorized healthcare providers involved in your treatment.

Security and Privacy: Your medical information will be shared securely and in compliance with all applicable laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). Access to your records will be restricted to healthcare providers directly involved in your care.

Right to Withdraw Consent: You have the right to withdraw your consent for HIE participation at any time. However, please note that this may limit the availability of your medical information to other healthcare providers during your treatment.

Information Shared: The types of information that may be shared through the HIE include, but are not limited to, diagnoses, medication lists, allergies, lab results, and treatment history.

Please indicate your consent or decline to participate in the HIE network by checking the appropriate box below:

- ☐ I consent to the sharing of my medical information through the Health Information Exchange (HIE) network.
- ☐ I decline to participate in the Health Information Exchange (HIE) network, and I understand that this decision may limit the availability of my medical information to other healthcare providers.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

CCM - Chronic Care Management Patient Consent Form

A message from your providers:

Your health is very important to us and our staff. Our goals are to: - Keep you as healthy as possible - Provide you with the best care - Keep you out of the hospital - Minimize the costs and inconvenience of unnecessary visits to doctors, labs, or urgent care facilities.
We encourage all eligible patients to participate in the Chronic Care Management (CCM) program.

What are CCM Services?
Chronic Care Management (CCM) services help manage your health between office visits. The program provides a series of non-face-to-face activities and additional services especially for our CCM patients. For example:
- You will have a dedicated Care Team that is familiar with your conditions
- We actively help you manage all your medications
- We help coordinate your care with your other doctors
- We share your health information only with other authorized providers

Your Care Plan
Your Care Plan includes valuable information that will help you understand your medical conditions. Your Care Plan will help you to be as healthy as possible. Your caregivers and other authorized providers can access your Care Plan 24/7 using our secure medical portal in the event you require care when we are not available.

How much does this cost?
The answer depends on your insurance. Each month, after we provide you with a minimum of 20 minutes of non-face-to-face services, we will bill your insurer(s). Either you or your supplementary insurer may be responsible for any deductible or co-pay.

What if I change my mind?
You may stop this service at any time, for any reason. If you choose to stop the service, we will provide it only through the last day of the calendar month of your decision. Your signature is required to end Chronic Care Management services, so please ask my staff for the CCM revocation form. You can only give CCM consent to one provider at a time. If another physician has offered to provide CCM, you will have to choose which provider is best able to treat and manage all your conditions. Please let me or my staff know if you change your mind, or if you have any questions.

How do I get started?
Signing this Chronic Care Management - Patient Consent Form allows us to begin immediately providing you with CCM services.

Your Consent

I agree to participate in the Chronic Care Management program. Yes _____ No_____

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Telemedicine Consent

When necessary, some services offered by My Whole Health Solutions may be delivered outside of our facilities through alternative means, such as by phone or via online/virtual platforms. While all of our services are confidential, it is important to acknowledge that utilizing these alternative methods introduces specific confidentiality limitations.

By consenting to receive virtual services through these platforms, you agree that the sessions will remain private and confidential, with only individuals you approve permitted to listen or observe. You also agree that neither you nor anyone else present in your home will record any part of the service delivery.

We are committed to safeguarding your private health information in compliance with HIPAA regulations, which encompass our electronic case records, including progress notes and individual treatment/case management plans. In the course of treatment or case management, we may utilize technology that is either newly developed or not specifically designed for clinical use, which may not fully comply with HIPAA standards. This includes, but is not limited to, digital apps employed for therapy, and/or cognitive testing.

If you consent to the use of these technologies, we request your agreement to a limited waiver of your HIPAA privacy rights. While we will make every effort to protect your or your family's privacy during and after the use of these tools, please understand that there may be limitations to our ability to do so.

I authorize My Whole Health Solutions to allow me, or the patient, to participate in telemedicine services, which may be conducted via video or telephone (videoconferencing). The type of service to be provided through telemedicine includes Primary Care Services and Behavioral Health Services.

I understand that this service is not equivalent to an in-person visit with a healthcare provider, as I, the patient, will not be in the same room as the healthcare provider delivering the service. I acknowledge that certain aspects of my care and treatment that require physical tests or examinations may be performed at my location under the guidance of the telemedicine provider, including assessments of physical and mental health and vital signs.

My provider has thoroughly explained the nature and purpose of the video-conferencing technology, including potential risks, benefits, and complications (both known and unknown) that may arise during the telemedicine session. I have also been informed of alternatives to telemedicine, such as in-person visits, and I understand the risks associated with not using telemedicine.

I recognize that there are potential risks related to the use of this technology, including interruptions, unauthorized access by third parties, and technical difficulties. Either I or my healthcare provider may discontinue the telemedicine service if the videoconferencing connection is deemed inadequate.

I understand that the telemedicine session will not be audio or video recorded at any time. I consent to the sharing of my healthcare information with other individuals for scheduling and billing purposes. I also agree to allow individuals, such as interpreters, to be present during the telemedicine service for operational support if necessary, and I will be informed of their presence.

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Telemedicine Consent

I recognize that there are potential risks related to the use of this technology, including interruptions, unauthorized access by third parties, and technical difficulties. Either I or my healthcare provider may discontinue the telemedicine service if the videoconferencing connection is deemed inadequate.

I understand that the telemedicine session will not be audio or video recorded at any time. I consent to the sharing of my healthcare information with other individuals for scheduling and billing purposes. I also agree to allow individuals, such as interpreters, to be present during the telemedicine service for operational support if necessary, and I will be informed of their presence.

If safety concerns necessitate additional individuals to be present, my or my guardian's permission may not be required. I acknowledge my right to request the following:

1. Omission of specific sensitive details from my medical history or physical examination, or
2. Non-medical personnel to leave the telemedicine room at any time, unless mandated for safety, or
3. Termination of the service at any time.

In emergency situations, I understand that it is the telemedicine provider's responsibility to advise my local healthcare provider regarding necessary care and treatment. The telemedicine provider will conclude the service upon termination of the video-conference connection.

I understand that my insurance will be billed by both the local healthcare provider and the telemedicine healthcare provider for services rendered. If my insurance does not cover telemedicine services, I will be billed directly by both providers.

My consent to participate in this telemedicine service will remain in effect for the duration of the specific service identified above or until I revoke my consent in writing.

I acknowledge that no guarantees or assurances have been made regarding the results of this service. Additionally, I understand that the MWHS Late/Cancellation policy applies to telemedicine visits: if a patient no-show or cancels on the same day for three appointments within six months, they will be restricted to same-day appointments only, with their scheduling ability reassessed after three months.

Telehealth appointments can occur up to 15 minutes before or after the scheduled time.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Advanced Directives

An Advance Directive is a legal document that enables an individual to provide instructions regarding their future medical care or to appoint another person or persons to make medical decisions on their behalf in the event they lose the capacity to make such decisions. The primary forms of Advance Directives include the Living Will and the Durable Power of Attorney for Health Care.

The Living Will
Any adult may, at any time, execute a written declaration to withhold or withdraw life-sustaining procedures should they find themselves in a terminal and irreversible condition, or in a persistent, profound comatose state with no reasonable chance of recovery.

The Durable Power of Attorney
Any adult may, at any time, designate another individual to make treatment decisions on their behalf by executing a Durable Power of Attorney, should they become unable to actively participate in their own medical care.

Please acknowledge the following statements:
- I have been informed of my rights to formulate advance directives.
- I understand that My Whole Health Solutions can provide me with an Advance Directive form.
- I acknowledge that I am not required to have an advance directive in order to receive medical treatment at My Whole Health Solutions.

Additional Information on Advance Directives:
You have the right to make decisions regarding your medical treatment. An Advance Health Care Directive enables you to designate an individual to advocate for you and specify the types of treatments you desire in the event that you become incapacitated and unable to make healthcare decisions.
In Maryland, the section of an advance directive that allows you to designate an agent for healthcare decisions is referred to as a Power of Attorney for Health Care. Conversely, the portion where you can articulate your treatment preferences is known as an Individual Health Care Instruction.

Who Can Create an Advance Directive?
Any individual who is 18 years or older and capable of making their own medical decisions may create an advance directive. Legal representation is not required for this process.

Who Can Be Appointed as My Agent?
You may select an adult relative or another trusted individual to act on your behalf during medical decision-making.

When Does My Agent Begin Making Medical Decisions?
Typically, your healthcare agent will assume decision-making responsibilities only after you are no longer able to do so. However, if you prefer, you can specify in the Power of Attorney for Health Care that your agent should begin making decisions immediately.

How Will My Agent Know My Wishes?
Once you have selected your agent, it is important to discuss your preferences with them. Given that treatment decisions can be complex, having your agent informed about your wishes is beneficial. Additionally, you may document your preferences within your advance directive.

My Whole Health Solutions
COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

ClinicalStaff@MyWholeHealthSolutions.com
www.MyWholeHealthSolutions.com
1125 West Street
Suite 200 #311
Annapolis, MD 21401

Advanced Directives Continued

What If I Choose Not to Name an Agent?
You can still outline your wishes in an advance directive without appointing an agent. You may express your desire for life-sustaining treatment to be continued or your preference for treatment to be withheld. You can also communicate your views on pain management and other medical interventions. Even in the absence of a written Individual Health Care Instruction, you can discuss your wishes with your physician and request that they be noted in your medical record. Engaging in conversations with family members or friends is also advisable, though documenting your wishes can facilitate adherence to them.

What If I Change My Mind?
You have the right to modify or revoke your advance directive at any time, as long as you are able to convey your wishes. To change your designated healthcare decision-maker, you must provide a signed statement or inform your attending physician.

What Occurs When Others Make Decisions Regarding My Treatment?
The same principles apply to anyone making healthcare decisions on your behalf—whether a healthcare agent, a surrogate designated by you, or an individual appointed by the court. All must comply with your Health Care Instructions or, in their absence, your general treatment preferences, including the discontinuation of treatment if desired. If your treatment preferences are unknown, the surrogate is expected to act in your best interest. Healthcare providers are obligated to follow the decisions made by your agent or surrogate unless the requested treatment is deemed inappropriate or ineffective. Should conflicts arise that cannot be resolved, the provider must make reasonable efforts to find an alternative healthcare provider to continue your treatment.

Will I Still Receive Treatment If I Do Not Create an Advance Directive?
Yes, you will continue to receive medical care. However, it is important to note that if you become incapacitated and unable to make decisions, someone else will need to assume that responsibility.
Key Points to Remember:

- A Power of Attorney for Health Care allows you to appoint an agent to make treatment decisions on your behalf. Your agent can make most medical decisions—not solely those involving life-sustaining treatment—when you are unable to communicate. If you choose, you can authorize your agent to make decisions immediately.
- An Individual Health Care Instruction can be established by documenting your healthcare preferences or by discussing them with your doctor and requesting that your wishes be recorded in your medical file. This instruction serves as a clear guide for your doctor and anyone else who may make treatment decisions on your behalf.

If you are interested in completing an Advance Directive and/or designating a Power of Attorney, the staff at My Whole Health Solutions can provide you with the necessary form to facilitate this process.

Signature of Patient or Patient's Representative	Date
Printed Name	Representative's Relationship to Patient
Witness (optional)	Date