Thank you for partnering with us on your healthcare journey!

Willwood Consulting Services is pleased to be partnering with you on your healthcare journey!

To get started in your engagement with Willwood and our Practice, we ask that you please read and sign the included consent forms, which include:

- ☐ One signature required for Consent to Treat
- ☐ One signature required for Consent to Release Medical Information

Overall, these documents help make sure you are aware of your rights, help to protect those rights, and help us provide you with the best care we can.

If you have any questions, you can contact us at 773-234-8340, and we will be happy to walk you through the forms.

Sincerely,

Willwood Consulting Services

CONSENT FORM

Annual General Consent for Care and Treatment

I voluntarily request and consent to the rendering of reasonable and necessary healthcare services by Willwood Consulting Services ("Willwood") and its affiliates' practitioners, such as other Speech Languages Pathologists ("SLP"), or their designees. Healthcare services may include medical examinations, evaluation and management services, diagnostic and therapeutic procedures, medications, injections, care management and care coordination, and other services.

I understand that I have the right to discuss and question proposed healthcare services with my practitioner. I also have the right to consent or refuse to consent to such procedures or treatments. I know that I can also discontinue receiving healthcare services at any time. I understand that healthcare services are not an exact science, and that diagnosis and treatment may involve risks of injury or poor outcomes. I understand that healthcare services may be provided at locations under common ownership. I acknowledge that no guarantees have been made to me as to the result of healthcare services.

I further understand that it is my practitioner who has the medical knowledge and pertinent information on my condition and who is or will be recommending proposed treatment after adequately informing me of such, together with any risks and alternative treatment; and that it is the responsibility of my practitioner to obtain my informed consent to any proposed testing, treatment, intervention, or invasive procedure.

Annual Notice of Privacy Practices

Each affiliate of Willwood that provides healthcare services maintains a Notice of Privacy Practices ("Notice"). The Notice provides information about how the applicable Willwood affiliate might use and disclose your protected health information. If you would like a copy of this document, please reach out to our team at admin@willwoodconsultingservices.com or refer to the paper copy mailed to you.

Patient Rights and Responsibilities

Each affiliate of Willwood that provides healthcare services are committed to providing quality health care. Patients at Willwood have rights and responsibilities. If you would like a copy of this document, please reach out to our team at admin@willwoodconsultingservices.com or refer to the paper copy mailed to you.

Annual Patient Consent to Financial Responsibility

Willwood may be legally obligated to collect patient cost-sharing obligations, which may include deductibles, coinsurance, or copayments.

For professional services covered by your health care insurer, please call the phone number on your insurance card to find out your financial responsibility.

If all or part of the cost of the provider services is not covered, you will be responsible for the remaining balance, if permitted by our agreement with your health care insurer.

If Willwood is able to bill your insurer for the visit, you agree to assign Willwood all right, title, and interest in and to any payment due from any insurance policy, employee benefit plan, or another responsible third party.

Consent for Sharing Health Information

Release of Health Information to Family or Caregivers

Name	Relationship	Phone #	Other Phone #

Consistent with our Notice of Privacy Practices, Willwood is permitted to disclose certain health information to individuals involved in your care. Please help Willwood understand the individuals who are routinely involved in your care. Willwood may verbally release the following types of information to your family and caregivers:

- Scheduling/appointment information
- Medical information, including my symptoms, diagnosis, medications, and treatment plan
- Lab/test results

You may update this authorization at any time by contacting us at admin@willwoodconsultingservices.com or [773-234-8340].

Permission to Contact You Via Phone Call, Text Message, or E-mail

Willwood may contact you for continuing care purposes. These communications may include. but are not limited to appointment reminders, information about upcoming visits, notifications of new information available on your Website/Patient Portal, or preventive care reminders.

You consent to receive communications from Willwood and all of its independent contractors, business associates, agents and/or affiliates, including the use of autodialed calls and/or texts, robocalls, and artificial voices or prerecorded voices, about the care you receive, billing, collections and other account activities, and for advertisement and telemarketing purposes at the phone number(s) and/or email address(es) provided below, including your wireless number if provided. Willwood may contract with other organizations to manage or collect payments for the services provided to you (if applicable). This consent extends to telephone communications by those organizations as well.

You understand that you may be charged for calls or texts to your wireless number by your wireless carrier. You understand that your receipt of healthcare services is not conditioned upon your agreement to be contacted by phone, text message, or e-mail. You understand that you may opt out at any time by contacting Willwood when you receive care. You understand that certain communications described in this consent may be sent via unencrypted email or via text messages over an open network, that such communications are inherently unsecure, and that despite every effort we make to keep your information secure, there is no assurance of confidentiality of information communicated in this manner.

Insecure Transmission of Health Information
Despite every effort we make to keep your information secure, you understand that it is not possible to guarantee that any transfer of information over text messaging or email is 100% secure. As a result, Willwood cannot guarantee the absolute security of your information when it is sent to via a text message or email. By asking Willwood to transmit information through text messaging or through email, you accept the risk that the transmission is not secure, and that your information may be exposed to a third party.

Your contact information:

Phone Number (landline):	
Phone Number (cell phone):	
Email Address:	

If you want to opt out of receiving text messages, opt out here: ☐
If you want to opt of out receiving emails, opt out here: ☐

Signature to Consent Form

_____ _____
Patient Name Date of Birth of Patient

_____ _____
Signature of Patient (or Legal Representative) Date of Signature

If signed by a Legal Representative, please print name: _____

If signed by a Legal Representative, indicate relationship to patient (e.g., Court-Appointed Guardian, Healthcare Power of Attorney):

_____

Request to Release Patient Medical Information to Willwood

It is important for your providers to review your past medical information so they can provide you with the best care plan. This form directs your health care providers to share your health records with Willwood.

I hereby direct my health care providers (Health Care Provider) to release my medical information from all Health Care Provider physicians, hospitals, health clinics, or care centers, including individually identifiable Protected Health Information (PHI), to Willwood, via electronic fax.

I understand that I have the **right to access** my complete medical records maintained by my health care providers based on the federal HIPAA law. I understand that when I want my records to be sent to Willwood, I understand that I may be asked to provide information to the Health Care Provider to verify my identity.

Type of information I wish to be released to Willwood Consulting Services:

My entire medical record.

Type of information not to be released to Willwood Consulting Services:

CONFIDENTIAL INFORMATION PROTECTED BY STATE/FEDERAL LAW:
I would like the following information excluded from the information released to Willwood:
___Drug or Alcoholism Abuse Diagnosis/Treatment
___Mental Health Diagnosis/Treatment
___Sexually Transmitted Disease or AIDS/HIV Diagnosis/Treatment/Counseling

Signature to Consent to Release Medical Information Form

_____ _____
Patient Name Date of Birth of Patient

_____ _____
Signature of Patient (or Legal Representative) Date of Signature

If signed by a Legal Representative, please print name: _____

If signed by a Legal Representative, indicate relationship to patient (e.g., Court-Appointed Guardian, Healthcare Power of Attorney):

_____