SUNFLOWER MEDSPA

Consent to Treat

A. Consent for Examination and Treatment: I hereby authorize the providers and employees of Sunflower Medspa to provide medical treatment/services which includes, but is not limited to, performing and administering tests and diagnostic procedures that are deemed necessary, including, but not limited to, imaging examinations, blood tests and other laboratory procedures as may be required by the hospital, clinic, or may be ordered by my physician(s) or persons working under the general and/or special instructions of my physician(s).

1. I understand and agree that this consent covers all authorized persons, including but not limited to physicians, residents, nurse practitioners, physicians' assistants, specialists, consultants, student nurses, and independently contracted physicians, who are called upon by the provider in charge, to carry out the diagnostic procedures and medical or surgical treatment.
2. I hereby authorize Sunflower Medspa to retain or dispose of any specimens or tissue, should there be such remaining from any test or procedure.
3. I hereby authorize and give consent for Sunflower Medspa providers and employees to take photographs, images or videotapes of such diagnostic, surgical or treatment procedures of patient as may be required by Sunflower Medspa or as may be ordered by a provider. I further acknowledge and agree that Sunflower Medspa may use cameras or other devices for patient monitoring. I acknowledge and accept that the materials created through this agreement will be the property of Sunflower Medspa and will not be returned to me.
4. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the outcome of any tests, procedures or treatment.
5. I hereby release and discharge Sunflower Medspa from any liability, claims, or legal actions that may arise including those made by myself, my heirs, representatives, executors, administrators, or any other individuals acting on my behalf or on behalf of my estate.
6. By signing below, I hereby acknowledge that I have completely read and understand the above release agreement.

B. Acceptance of Financial Responsibility: I agree that in consideration of the services and supplies that have been or will be furnished to the patient, I am hereby obligated to pay all charges made for or on the account of the patient according to the standard rates (in effect at the time the services and supplies are delivered) established by Sunflower Medspa I understand that I am responsible for all charges. No refunds will be distributed.

C. Telehealth consent: Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

*Client health records
*Live two-way audio and video
*Output data from health devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

1. Expected Benefits:

*Improved access to care by enabling a client to remain in his/her provider's office (or at a remote site) while the providers obtain test results and consults from practitioners at distant/other sites.
*More efficient client evaluation and management.
*Obtaining expertise of a distant specialist.

2. Possible Risks:

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

*In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the providers and consultant(s)
*Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment
*In very rare instances, security protocols could fail, causing a breach of privacy of personal health information
*In rare cases, a lack of access to complete health records may result in interactions or allergic reactions or other judgment errors.

3. **By signing this form, I understand the following:**

- I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.

- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
- I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
- I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
- I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

4. I have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

D. Communication Authorization: I hereby authorize Sunflower Medspa and its representatives, along with any billing service or collection agent who may work on their behalf, to contact me on my cell phone and/or home phone using prerecorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication. This includes, but is not limited to, appointment reminders, yearly physical exam reminders, preventive care reminders, patient campaigns, welcome calls, and calls about account balances on my account or any account on which I am listed as a guarantor. I understand I have the right to opt out of these communications at any time.

E.TERM: This authorization is valid for this and subsequent care/treatment I receive at Sunflower Medspa and will remain valid unless/until revoked in writing by me.

Patient/Legal Guardian Printed Name:_____Date: _____

Patient/Legal Guardian Signature:_____ Date: _____

Relationship to Patient:_____

Employee Representative Name: _____Date:_____

Employee Representative Signature: _____Date:_____

Sunflower Medspa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.