Authorization for Treatment

The patient and others whose signatures are attached below do hereby consent to any and all medical treatments, which may deem advisable by his or her physician or nurse practitioner. The intention hereof being to grant authority to administer and to perform all/any examinations, treatments, medications including anesthetics, procedures and diagnostic testing which may now or during the patient’s care be deemed advisable or necessary.

Assignment of benefits

I/We hereby transfer, assign and convey all my/our rights, title and interest in and all benefits due me/us, if any by reason of services described in the statement rendered and as provided for in any contract or policy of insurance under which I/we may be an insured or beneficiary and I direct said insurance company(s) and Medicare to pay directly to Welllife all such benefits. I/we also assign my/our causes of action against any and all third parties who may be responsible or liable for the injuries requiring treatment by Welllife, up to but not to exceed the amount of charges described in statements rendered. I agree to pay Welllife any remaining balance a required in the processing of y healthcare claims after insurance payment or denial of coverage under this assignment of benefits. I also authorize the release of any information.

Authorization/Precertification

If my group or private insurance policy requires prior certification, authorization, second opinions, or any other type of utilization review function. I understand that I am responsible for compliance with these and all other terms of my policy.

Patient Financial Responsibility

Welllife’s election to pursue one or more forms of collection shall not constitute a waiver of its right to pursue other collection measures it deems advisable or necessary. All such remedies shall be cumulative in nature. Venue for collection shall be Cleveland, Texas. This agreement shall not require payment by any person in contravention of any state or federal statue, rule or regulation.

Advance Directive Acknowledgment

Do you have a living will? \_\_yes\_\_no Would you like information on a living will\_\_\_yes\_\_\_no

Telehealth Consent

I hereby consent to engaging in telemedicine with Welllife and affiliates. I understand that “telehealth” includes includes the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually to healthcare practitioners.

I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured.

The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during my visit is generally confidential. I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical record could be interrupted by unauthorized persons.

In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face service. I also understand that if my provider believes that I would be better served by another form of treatment (ie. Face-to-face, emergent or specialist) I will be referred to where services are provided in my area.

For Minors: This consent allows for telehealth services.

I allow another individual to participate in the session, and I acknowledge receipt of privacy practices for email and electronic communications.

Mid-level Practitioner Acknowledgement

I acknowledge that it is the policy of Welllife to delegate healthcare tasks or general medical services to a qualified nurse practitioner. This allows for more effective utilization of the skills of the physicians. Delegation of such duty is consistent with due regard for the health and safety of our patients and in keeping with sound medical practice.

I fully understand that the nurse practitioner is NOT A PHYSICIAN and that I have the right to withdraw consent for treatment and or be referred to a physician.

I further acknowledge that the general medical services provided me by a nurse practitioner are the responsibility of the delegating physician both professionally and legally for the acts of such allied health personnel rendering care and treatment of his/her patients.

Finally, I understand that that there are potential risks and benefits to treatment and that despite my efforts and the efforts of my provider, my condition may not be improved and in some cases worsen. If my symptoms do not improve but worsens, I will contact my provider and/or seek emergency care.

I understand that I have a right to access my medical information and copies of medical records.

I have read the above in its entirety and fully understand Welllife’s policy regarding nurse practitioners and do hereby consent to receiving general medical services from the nurse practitioner.

I have read and understand the information provided above. I have discussed it and all of my questions have been answered to my satisfaction.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/ Parent or Legally Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date