ConnectCare & Wellness LLC.

GENERAL CONSENT FOR TREATMENT

Patient Name:_____DOB:_____

Practice Name:_____

- I, the undersigned patient and/or legal representative or relative, hereby consent to, authorize, and request that ConnectCare & Wellness LLC Group and its medical personnel perform ambulatory care services, including but not limited to medical examinations, evaluations, treatments, procedures, diagnostic tests, laboratory tests, vaccinations, and immunizations, as may be deemed advisable or necessary during the course of my or the patient's care. I understand that I have the right to refuse any suggested medical treatment, examination, evaluation, or test at any time.
- I understand that this consent and authorization for treatment is valid and will remain in full force and effect for the duration of my treatment at this facility unless and until I revoke or otherwise withdraw my consent in writing.
- I understand and agree that I am ultimately responsible for all charges associated with the ambulatory care services I receive at this facility. In the event that my insurance company does not pay the anticipated portion of any charges for any reason, I understand and agree to be responsible for all unpaid amounts.
- I acknowledge that I have been given a copy of, and had the opportunity to review and understand, the CCWS Joint Notice of Privacy Practices. I understand and acknowledge that this notice describes how my protected health information may be used or disclosed for the purpose of carrying out medical treatment, billing and payment activities, and other healthcare operations. I hereby consent to and authorize such use and disclosure of my protected health information.
- I understand that an accurate medication history is very important in helping to treat my condition and to avoid potentially dangerous drug interactions. I agree that CCWS may request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Patient Signature or Authorized Person:_____Date:_____

Witness Signature:_____Date:_____

Relationship if Signature is Not Patient:_____

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