McCoy Health
Live Your Best Life Here

HIPAA AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____
Medical Record #: _____ **Social Security #:** _____
Address: _____
City: _____ State: _____
Zip: _____ Home Phone #: (_____) _____-_____

EMAIL: _____

I hereby authorize use or disclosure of protected health information about me as described below.

The following specific person/class of person/facility is authorized to use or disclose information about me:
McCoy Health or the physician individually to release any of my or my dependent's medical or incidental nonpublic
personal information.

Name: Cathy McCoy

The following person (or class of persons) may receive disclosure of protected health information about me:
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: (_____) _____-_____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: (_____) _____-_____
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: (_____) _____-_____

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The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:

[ ] **YES,** DISCLOSE THIS INFORMATION *_____

[ ] **NO, DO NOT** DISCLOSE THIS INFORMATION * _____

1. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.
2. I may revoke this authorization by notifying MCCOY HEALTH in writing to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
3. My purpose/use of the information is for
   _____
4. This authorization expires on ONE YEAR FROM THE DATE SIGNED.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE_____ **DATE:** _____
(If different from patient)
GUARANTOR NAME (Please Print):_____

WITNESS SIGNATURE: _____ **DATE:** _____

WITNESS NAME (Please Print): Cathy McCoy

INTERPRETER'S ATTESTATION (if applicable):
I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form, and that the person giving consent has indicated their understanding of the contents.

_____ _____
Signature of Interpreter Date and Time

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PATIENT DISCLOSURE AND CONSENT FORM

Patient Name: _____ Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to MCCOY HEALTH, LLC or the physician individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and WHETHER OR NOT the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that MCCOY HEALTH, LLC is unable to collect from my insurance carrier for whatever reason. I certify that I have read and agree to MCCOY HEALTH, LLC payment policy. I am eligible for the insurance indicated on this form. I hereby assign to MCCOY HEALTH, LLC all money to which I am entitled for medical expenses related to the services performed from time to time by MCCOY HEALTH, LLC, but not to exceed my indebtedness to MCCOY HEALTH, LLC. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $20.00 returned check fee will be charged for checks returned due to insufficient funds.

MEDICARE/MEDICAID/TRICARE INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to MCCOY HEALTH, LLC or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the MCCOY HEALTH, LLC Patient Information Privacy Policy. I hereby authorize MCCOY HEALTH, LLC or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL:

I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. I hereby authorize MCCOY HEALTH, LLC representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to things such as appointment reminders, referral arrangements, and laboratory results. I choose to receive communications from MCCOY HEALTH, LLC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. Comments submitted on surveys may be anonymously shared on the McCoy Health Public Website. I understand that I have the right to rescind this authorization at any time by notifying MCCOY HEALTH, LLC to that effect in writing.

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PATIENT DISCLOSURE AND CONSENT FORM

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

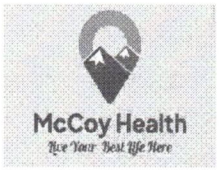
CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my MCCOY HEALTH, LLC physician or his or her designee.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If different from patient)
GUARANTOR NAME (Please Print): _____

INTERPRETER'S ATTESTATION (if applicable):
I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form, and that the person giving consent has indicated their understanding of the contents.

_____ _____
Signature of Interpreter Date and Time



TELEMEDICINE CONSENT

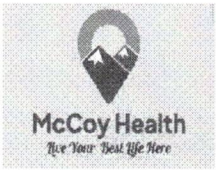
By signing this form, I understand and agree with the following:

Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate on the telehealth/telemedicine service, and I agree to share my personal information with such family members, caregivers, legal representatives or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.
Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data transmitted electronically
- Videos, pictures, text messages, audio and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing and healthcare operations. By agreeing to use the telehealth/telemedicine services, I am consenting to MCCOY HEALTH, LLC sharing of my protected health information with certain third parties as more fully described in MCCOY HEALTH, LLC Privacy Policy. I understand, agree, and expressly consent to MCCOY HEALTH, LLC obtaining, using, storing, and disseminating to necessary third parties, information about me, including my image, as necessary to provide the telehealth/telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session. This is so they can operate or repair the video or audio equipment used. These persons will adhere to applicable privacy and security policies.



Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient or care team. I hereby release and hold harmless MCCOY HEALTH, LLC and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

I understand and agree that the health information I provide at the time of my telehealth/telemedicine service may be the only source of health information used by the medical professionals during my evaluation and treatment at the time of my telehealth/telemedicine visit, and that such professionals may not have access to my full medical record or information held at MCCOY HEALTH, LLC.

I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit.
I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert to traditional in-person clinic services.
I understand that if I withdraw my consent for telehealth/telemedicine, it will not affect any future services or care benefits to which I am entitled.
All my questions have been answered to my satisfaction.
I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.
By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

Signature of Patient or Patient's Legal Representative Date and Time

Printed Name of Patient or Patient's Legal Representative Relationship to the Patient

INTERPRETER'S ATTESTATION (if applicable):
I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form, and that the person giving consent has indicated their understanding of the contents.

Signature of Interpreter Date and Time

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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