Consent to Treat

Belvonae Health & Wellness
Provider Name: Angela Stevens, MSN, APRN, PMHNP-BC

1. Consent for Medical Treatment

I, the undersigned patient or legal guardian, hereby authorize Belvonae Health & Wellness and its healthcare providers to conduct assessments, examinations, treatments, and procedures as deemed necessary for my care. This includes but is not limited to:

Routine medical exams and procedures

Diagnostic tests (e.g., blood tests, imaging)

Administration of medications

Referral to specialists if necessary

Mental health assessments and treatments

Other treatments or procedures deemed necessary by the healthcare provider

2. Understanding of Risks and Benefits

I understand that healthcare services provided may involve certain risks, including but not limited to potential side effects from medications, discomfort from procedures, or complications from treatments.

The nature and purpose of the proposed treatments, as well as any potential risks and benefits, will be explained to me by the healthcare provider. I have the opportunity to ask questions and have them answered to my satisfaction.

3. Right to Refuse Treatment

I understand that I have the right to refuse any proposed treatment or procedure.

I acknowledge that refusing recommended treatment may have implications for my health, which will be explained to me by my healthcare provider.

4. Confidentiality and Privacy

I understand that my medical information is confidential and protected under state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

I consent to the release of my medical information to other healthcare providers or facilities involved in my care, as necessary, and to my insurance company for billing purposes.

I understand that Belvonae Health & Wellness will take all reasonable measures to protect my privacy and ensure that my medical information is kept secure.

5. Financial Responsibility

I understand that I am financially responsible for all charges associated with my care, including co-pays, deductibles, and any charges not covered by my insurance.

I agree to provide accurate and up-to-date insurance information and understand that it is my responsibility to confirm coverage for services provided.

I understand that any outstanding balances must be paid promptly, and failure to do so may result in additional charges or referral to a collections agency.

6. Consent for Telemedicine

I understand that if I receive telemedicine services, these will be conducted through secure, encrypted technology to ensure privacy and confidentiality.

I acknowledge that telemedicine involves risks similar to those of in-person visits and may be subject to technical limitations.

7. Emergency Care

In the event of a medical emergency while under the care of Belvonae Health & Wellness, I consent to receiving any emergency medical treatment deemed necessary until I can be safely transferred to an appropriate facility.

Patient/Guardian Consent:

I have read, understood, and agree to the information provided in this consent form. I voluntarily consent to receive medical treatment from Belvonae Health & Wellness. I understand that I have the right to withdraw my consent at any time by notifying the practice in writing.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____