GENERAL HEALTH TREATMENT CONSENT FORM

Privacy Notice

JCHW PLLC will not share your protected health information without prior written consent with the exception to the following circumstances: medical emergency requiring release of information for treatment purposes, in situations required by law such as public health required reporting, suspected child, domestic or elder abuse, when subpoenaed by a court of law, for purposes of collecting payment, or if requested by parent/guardian of a minor child or activated POA. In the event we are required to disclose your protected health information we will only disclose the minimum amount of information necessary to fulfill requirements outlined in exceptions.

Medical Records

You have the right to obtain a copy of your medical record. A signed form authorizing release of your medical record is required. Please allow 7-10 business days for processing. Administrative fees may apply for physical copies of records.

Consent for Treatment

I herby authorize Jones Concierge Health and Wellness PLLC and any employees working under the direction of the primary clinician to provide healthcare services to me, (or my minor child, or the individual for which I am named and activated as POA) which may include (but are not limited to) preventative health services, diagnostic tests, therapeutic interventions, rehabilitative services, review of my medical history, physical examination, counseling, review of my medical records, collaboration with other healthcare providers involved in my care, referrals to other healthcare providers for additional treatment, treatment plans, prescription medications, OTC medications, medication samples, durable medical equipment, vitamins, minerals and supplements, or additional appropriate therapies recommended by my healthcare provider. I am aware that the treatment plans are not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to results of such diagnostic procedures or treatment.

Telehealth Consent: I acknowledge that my diagnosis and treatment plan will be limited by what my healthcare provider is able to evaluate from my chief complaint, history of present illness, review of systems and limited observations as a physical exam is not possible. I understand it is my responsibility to communicate with my healthcare provider if my symptoms do not improve in a reasonable amount of time or if my symptoms worsen. I acknowledge that if my condition becomes serious, I should promptly seek in-person emergency care and I should call 911 immediately for any life-threatening situations.

House Calls Consent: I authorize the clinicians and/or designated employees of JCHW to provide healthcare services in my home. I understand that the health services that can be provided in my home are limited. My healthcare provider may recommend additional evaluation

or procedures that require a visit to a clinic or emergency setting as deemed appropriate. Any costs associated with these additional health services not directly provided by JCHW will be my responsibility to cover and/or discuss with the rendering provider or healthcare organization.

Financial Policy

I acknowledge that payment for health services provided by JCHW is due at the time of service. I understand that payment covers a consultation fee for professional services that includes an evaluation of my health condition, diagnosis, and treatment plan. I understand that my treatment plan will be based on my clinician's expertise and judgement and disagreements related to my plan of care won't negate my obligation to pay or entitle me to any refund.