Consent to treat

WellBe SENIOR MEDICAL

Patient first name: _____ Patient last name: _____

Date of birth: __/__/____ Home phone: _____ Mobile phone: _____

Street address: _____ City: _____

State: _____ Zip code: _____ Email address: _____

- I consent to allow WellBe Senior Medical to provide diagnostics and other healthcare services. I understand that these services may include examinations and treatments, and providers will not provide any guarantees as a result of treatment and/or examinations.
- I acknowledge that I have received a copy of WellBe Senior Medical's Notice of Privacy Practices, and I may contact WellBe in writing regarding my rights and options explained in the Notice of Privacy Practices.

Communication:

- By providing my signature below, I consent that WellBe Senior Medical can call, email, or text me regarding my WellBe appointments and care notifications. I understand that I can opt out of notifications at any time, and that notifications are not a mandatory condition of my WellBe treatment.

Consent for telemedicine:

- I consent to participate and proceed with a telemedicine consultation/visit, and I acknowledge that I have been offered alternatives to my telemedicine consultation.
- I acknowledge and understand the risks and benefits of telemedicine have been shared with me, including the limitations of evaluation and management.
- I consent and understand that during my telemedicine consultation/visit, details of my medical history, examinations, x-rays, and tests will be discussed through the use of interactive audio, video, and/or telecommunication technology.
- I understand that the laws that protect the confidentiality of my medical information also apply to telemedicine, and that no information obtained that identifies me will be sold, shared, or disclosed to other entities without my consent.
- I understand that at any time, I may withdraw my consent for telehealth treatment.

Uses and disclosures of health information and medical records request:

- I understand that WellBe participates in the Health Information Exchange (HIE) for my state and consent to WellBe to access and disclose my health information in the HIE as part of my healthcare. Information accessed and disclosed may include sensitive information.
- Please consider this a request for the exercise of my rights under federal and state laws to access my healthcare information. I understand that my request will be acted upon no later than the time frames allowed by federal and state laws. I request the release of my medical records or other healthcare information, including chart notes, reports, correspondence, and other written information concerning my health and treatment, to WellBe Senior Medical.

☐ **I have read and acknowledged the information above.**

Signature of patient or patient representative: _____ Date: __/__/____