

General Consent to Treat and Office Policies Acknowledgment

Patient Name: _____ Date of Birth: _____

Consent to Treatment

On an ongoing basis, I request, consent, and authorize HealthFirst Family Care Center to perform diagnostic and therapeutic tests, procedures and provide general care and treatment as determined necessary and/or ordered by those health care professionals involved in my care. This includes, yet not limited to, the performance of physical examinations, taking blood, fluids, or other bodily samples.

Be advised that laboratory services provided by HealthFirst may be processed by an outside laboratory. If your health insurance requires you to utilize a participating or in-network laboratory, please inform the nurse prior to receiving lab services. **You will be billed separately by the laboratory and should be aware of your insurance coverage for these services.**

I understand that I have the right to object or refuse any recommended care plans when discussing with my provider.

Behavioral Health Services

HealthFirst Family Care Center provides an integrated team approach for the coordination of primary and behavioral health care. As an integrated team all staff members work together, improving communication among providers by sharing information in one medical record and decision making, as well as shared responsibility for patient care plan. Behavioral Health Services are available to all individuals. I consent to the sharing of my Private Health Information (PHI) to formulate a plan of care. I understand health care professionals in training may be involved in my care and I consent to their involvement in it under appropriate supervision.

Substance Use Disorder Services

By completing and signing this form, you will be allowing your 42 CFR Part 2 -- substance use disorder (SUD) treatment provider to share information about your 42 CFR Part 2 -- substance use disorder treatment with other members of your health care team for purpose of treatment, payment, and health care operations (TPO).

Acknowledgement of Rights

I understand that my substance use disorder treatment records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Treatment Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts 160 & 164 and cannot be disclosed without my written consent unless provided by the regulations and state law. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and if so, may not be protected by federal or state law, however federal law prohibits the recipient of information disclosed pursuant to this authorization from making any further disclosure of substance use disorder treatment records without the express written consent of the person to whom it pertains or as otherwise permitted by law.

Medication History Consent

I authorize HealthFirst Family Care Center and its providers to access my medication history from pharmacies, other healthcare providers, and my insurance company to ensure safe, coordinated care.

Artificial Intelligence (AI) Consent

HealthFirst Family Care Center may utilize AI-assisted tools for documentation, medical decision support, or communication. These tools are used under provider supervision and do not replace clinical judgment. This tool allows providers to focus more on you, the patient, and less on computer documentation.

Financial Responsibility & Payment Acknowledgment

I understand that I am financially responsible for all the charges associated with the services I receive at HealthFirst Family Care Center. I understand that my Protected Health Information (PHI) may be used in connection with billing statements sent to me and in

connection with checking for eligibility for health insurance coverage and preparing claims for my insurance company where appropriate.

I, _____ (Patients first and last name) authorize HealthFirst Family Care Center to release/disclose all information pertinent to the authorization of my services by my insurance company and pertinent to the billing for services I receive to _____ (Insurance Carrier/Third party payer). I authorize my health insurance or third-party payer to make direct payments to HealthFirst Family Care Center for services provided. I acknowledge that I am responsible for any co-payments, deductibles, or charges not covered by my health insurance.

I understand that I am financially responsible for any charges not covered by my insurance, including co-pays, deductibles, and services deemed non-covered or out-of-network.

Patients With Medicare Only

I request payment of authorized Medicare benefits be made either to me or on my behalf to HealthFirst Family Care Center for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the HealthFirst financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. (This payment authorization is valid for any service provided to a beneficiary during his/her lifetime, unless revoked.)

_____ If you have Medicare, please **initial** to confirm you have read and understand this above section.

Preferred Communication Methods and Consent/Authorization

Please indicate your preferred methods of communication (check all that apply):

- Phone Call (Voice including detailed messaging)
- Text Message (SMS)
- Email

I authorize HealthFirst Family Care Center to communicate with me regarding:

- Health Notifications
- Prescription Notifications
- Appointments
- Announcements
- Billing

I understand that while the office will take reasonable steps to protect my privacy, communications via phone, text, or email carry certain risks of unintended disclosure.

I have read, understand, and agree with the above information. Any questions I have about this consent have been answered.

Patient/ Parent/ Legal Guardian Signature
(Must be 18 years or older)

Date

If a parent/legal guardian, please print name here: _____