CityLife Health Consent for Treatment, Assignment of Benefits, and Acknowledgement of Privacy

CityLife Health offers certain health care services to members of our community (1) in CityLife Health, (2) through Community Care school-based services, and (3) through telehealth services. In order to receive health care services from CityLife Health please complete this form in its entirety.

Patient Name: _____ **Date of Birth:** _____

Name of Parent or Legal Guardian (if patient is 18 or younger): _____

Relationship to Patient (circle one): Mother / Father / Legal Guardian

I consent to care and treatment by the attending physician or non-physician health care provider with CityLife Health, their associates or assistants, and I acknowledge that no guarantees have been made about the outcome of the treatment. I understand that I must provide information about my/the patient's medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my knowledge and ability. If the patient is receiving school-based services, I consent to all general medical services offered by CityLife Health, through its school-based services. I consent for necessary medical tests, evaluations and management of my/the patient's medical care, preventive care (including but not limited to receiving vaccinations) and screening tests.

I understand that there are possible risks from taking a blood sample by finger stick, including: excessive bleeding; scarring (occurs when there have been multiple punctures in the same area); rarely, an infection; and, uncommonly, faintness from the procedure. Damage to blood cells from this method of collection can sometimes cause inaccurate test results and the need to repeat the test with blood drawn from a vein. If a venous blood draw is needed, additional risks may include discomfort at the site of puncture and possible bruising and swelling around the puncture site.

I understand that any test results must be reviewed by my personal physician for proper interpretation and medical diagnosis. If my physician is not at CityLife Health, then I understand it is my responsibility to provide the test results to my personal physician and seek any follow-up care from my physician.

I understand that if I received vaccines, I have received, read and/or had explained to me the Fact Sheet(s) on the vaccines(s) I received. I understand the risks and benefits related to the vaccines I received and have had a chance to ask questions. Any questions I asked were answered to my satisfaction. I have been advised that the patient should stay near the vaccination location for observation for approximately 15 minutes after the vaccine(s) is/are given.

I have had the opportunity to ask and have any questions answered about the risks, benefits, and alternatives of the medical care services provided by the health care provider rendering the services, and I understand that CityLife Neighborhood Clinics recommends that I do so before signing this consent form.

Teaching Clinics

I understand that medical residents, students, and CityLife Health approved observers may be involved in or observe my/the patient's care under the direct supervision of a CityLIfe Health care provider or staff member for an educational purpose.

Telehealth Services

If I/the patient receive telehealth services, I consent to the CityLIfe Health telehealth providers, and any associates, technical assistants, and/or other professionals as the telehealth provider deems necessary, participating in my/the patient's medical care by using telehealth services. I understand that the telehealth providers (1) may have their practice in a different location than the one where I/the patient may be physically present for the medical care; (2) may not have the opportunity to perform an in-person physical examination of me/the patient at the time telehealth services are provided; and (3) may rely on information provided by me/the patient before and during our telehealth services encounter. I also understand that in the event the telehealth services are interrupted due to a technology problem or an equipment failure, alternative means of communication may be implemented and/or an in-person medical evaluation with my/the patient's health care provider may be necessary. I understand that the level of care provided by CityLIfe Health, telehealth providers is to be the same level of care available through an in-person medical visit. if CityLIfe Health telehealth providers determine that the provision of telehealth services will not adequately address my/the patient's medical needs, the treating CityLife Health, telehealth provider(s) may require me/the patient to schedule and attend an in-person medical examination with my/the patient's health care provider.

I understand that if, after a telehealth services session, I/the patient experience any urgent medical symptoms or conditions, I will alert my/the patient's treating physician or, in the case of an emergency, I will dial 911 or go directly to the nearest emergency room.

I understand that after any telehealth services session, the CityLIfe Health telehealth providers will give me guidance regarding any appropriate follow-up care and, if required by law, must share information regarding my/the patient's telehealth services session with my/the patient's primary care physician. I hereby authorize CityLIfe Health telehealth providers to share such information, which may include but is not limited to copies of my/the patient's medical records, a report containing an explanation of the telehealth services provided to me/the patient, and/or any evaluation, analysis, or diagnosis of my/the patient's medical condition made by the CityLIfe Health telehealth providers.

Contact and Recording Policy

I agree that CityLife Health may contact me by telephone, text message or mobile application at any telephone number I provided to CityLife Health, including wireless telephone numbers, which may result in additional charges from the phone carrier. CityLife Health may also contact me by sending an email to any email address I provided. The numbers I provided CityLife Neighborhood Clinics may be used to communicate with me about the treatment, services provided, or for any other purpose. In the future, I understand that I may opt-out of receiving text messages by notifying CityLife Health in writing (including responding via text message).

I understand that in order to protect the privacy of CityLife Neighborhood Clinics' patients and workers, the use of recording devices (video or audio) is strictly prohibited while visiting CityLife Health

Assignment of Benefits and Financial Responsibility

I assign to CityLife Health, and any health care provider providing care and treatment to me, my child, or any person entitled to health care benefits for the care and treatment provided, any and all benefits for services provided under any insurance policies, including but not limited to Medicaid, Medicare, or any reimbursement from a health care plan. I understand that CityLife Health will be entitled to directly receive all insurance payments on my/the patient's behalf. The insurance information I provided to CityLife Health is accurate. I understand that providing inaccurate insurance information may result in me receiving a patient bill. If I receive a patient bill due to inaccurate insurance information, it is my responsibility to contact CityLIfe Health to provide correct insurance information so my insurance can be properly billed. If I lose insurance coverage after receiving medical services that would be covered if I kept my insurance, I agree to pay CityLife Health their applicable self-pay rate(s) for the services provided to me/the patient.

Release

I hereby release, discharge, and agree to hold harmless CityLife Health, CityLife-PA, P.C., Ampersand Health-PA, LLC, and their affiliates, employees, agents, officers, directors and representatives from any and all damages, losses, injuries or liability whatsoever which may arise from my participation in the care and treatment listed above.

By signing below, I acknowledge that I have read and understand this Consent for Treatment.

Signature of Patient/Legal Guardian: _____

Date: _____

Please provide the following contact information:

Home Address (include city, state and zip code): _____

Telephone Number (include area code): _____

Please provide the following insurance information (if not insured, leave blank):

Insurance Provider Name: _____

Policy ID#**:** _____

Notice of Privacy Practices Acknowledgment

I have received the HIPAA Notice of Privacy Practices ("Notice") from CityLife Health, and I have been given an opportunity to review it. I understand that:

- I have certain rights to privacy regarding my protected health information.
- CityLife Health can and will use my health information for purposes of my treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how CityLife Health may use and share my protected health information for other purposes.
- I have the rights regarding my protected health information listed in the Notice.
- CityLife Neighborhood Clinics has the right to change the Notice from time to time, and I can obtain a current copy of the Notice by following the instructions in the Notice.

Name of Patient/Legal Guardian: _____

Signature of Patient/Legal Guardian: _____ **Patient's Date of Birth:** _____

Date: _____

Telephone Authorization: Authorization for the services listed in this form was obtained by telephone from patient's proper representative, as the patient is a minor, or is not physically/mentally capable of giving the necessary authorization. Prior to this telephone authorization, the information outlined in this form was provided by _____ (practitioner providing services) to the patient's representative.

Print representative name: _____

Relationship to patient: _____

Witness: _____

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgment Form Signature

Name of Patient: _____ Date of Birth: _____

I attempted to obtain the patient's, or patient's representative's, signature on the HIPAA NOTICE of Privacy Practices Acknowledgment, but was unable to do so, as documented below:

Reason: _____

Name: _____ Date: _____Signature: _____