Healthy Wings
Family & Psychiatric Healthcare

GENERAL CONSENT

I hereby authorize nursing and medical evaluation, diagnosis, physical examination, laboratory testing, psychiatric or mental health therapy, and/or treatment or procedures at Healthy Wings LLC, d/b/a Healthy Wings Family & Psychiatric Healthcare, by its healthcare providers, clinicians, contractors, employees, and/or assigns (collectively referred to as "HWLLC"). HWLLC's scope of services includes some of the following:

- Diagnosis and treatment (including prescribing medications when appropriate) for common illnesses including psychiatric/mental health disorders;
- Labs and tests; treatment of minor abrasions, skin conditions, and/or injuries; common vaccinations;
- Department of Transportation's Commercial Motor Vehicle Drivers' exams, Medical Marijuana Certification exams, camp, sports, school, and/or college physicals;
- Wellness services designed to help patients identify lifestyle changes needed to improve their current and future health, including screenings and monitoring for thyroid disorders, diabetes, high blood pressure, and/or high cholesterol, etc., and/or programs and counseling for weight loss and smoking cessation.

You have the right to discuss with your healthcare provider any cultural, religious, spiritual, and/or other preferences that impact your visit or treatment plan. If you have any language or communication challenges, please notify the healthcare provider.

Email/Text Consent

I consent to receive text messages or emails from HWLLC on my cell phone or other devices. I understand that text messages and emails sent by HWLLC may include appointment reminders or changes in previously scheduled appointments or may provide advice or education. HWLLC does not charge for this service, but I understand that standard text messaging rates may apply as provided in my wireless plan. I have been advised that I may contact my carrier for pricing plans and details. I understand that I may revoke my request for further communications via text or email at any time by notifying HWLLC in writing. However, if I continue to communicate with HWLLC via text or email, HWLLC can assume that my consent remains valid.

Because e-mails sent over the Internet or texts sent over the control channel without encryption are not secure, I understand the risks associated with e-mail and text messaging, including, without limitation, that e-mails and text messages could be intercepted by unknown third parties; e-mail content can be changed without the knowledge of the sender or receiver; backup copies of my e-mail(s) may still exist even after the sender and receiver have deleted the messages; and e-mail can contain harmful viruses and other programs. HWLLC has recommended that I delete all text messages or emails as soon as possible after reviewing them to limit any unauthorized exposure.

Vaccination Services

HWLLC does not provide vaccination services. I understand the benefits and risks of the vaccine(s). I understand and consent to HWLLC sharing information related to vaccine(s) that I may have received and/or have previously been administered by others with the AZ State Immunization Information System for the sole purpose of archiving and/or retrieving such information.

Use or Disclosure of Health Information

HWLLC may use or release your health information to other healthcare provider(s) and/or their staff for treatment purposes, to third party payors and other third parties as necessary for HWLLC to obtain payment for services that you may receive. I understand and consent to HWLLC retrieving a historical record of my current and/or prior prescribed medications to assist in providing quality healthcare services to me or the minor child listed below. Please see the **HWLLC Notice of Privacy Practices & Patient-Provider Policies** for full details which you acknowledge will be a part of your Electronic Medical Record.

Patient Financial Responsibility

You are responsible for paying for services at the time they are provided, unless HWLLC has an agreement with your health plan or

Print Patient's Name: _____ Date of Birth: ____/ _____ / _____

insurer and the services are covered under the health plan or insurer. If HWLLC has an agreement with your health plan or insurer, you are responsible for paying a co-payment and/or deductible amounts at the time of service. It is understood, however, that **THE PATIENT AND/OR THE UNDERSIGNED ARE RESPONSIBLE FOR THE PAYMENT OF THE PATIENTS ACCOUNT; especially, if any policy that ensures the patient fails to make payment or timely payment (within 45 days of bill submission) to Healthy Wings Family & Psychiatric Healthcare and/or the Healthcare Provider. In addition, instead of sending you a bill, you hereby authorize HWLLC to automatically charge your balance to the credit card provided at the time of service.**

Notice of Self-Payment for Health Screenings and Administrative Services

Health screenings for Sports, Camp, School/College, Department of Transportation, Medical Marijuana Certifications or for work and/or Administrative Services may be limited services at HWLLC. **Your health plan or insurer or Medicaid WILL NOT pay for these services**. These services cannot be billed to your health plan, insurer, or Medicaid plan whether HWLLC accepts the plan or not.

You will be advised of the limited service requested and the related costs prior to the service being rendered by HWLLC.

Authorization to Obtain Needed Information:

I grant Healthy Wings LLC permission to obtain all medical information regarding me (which may contain confidential HIV/AIDS related information, communicable disease related information, information relating to mental health, medications prescribed, immunizations, and/or alcohol/drug use) that any health care provider may have on record for the purpose of further medical care.

Information to be requested: History & Physical; Discharge Summary; Pathology Reports; Physician's Progress Notes; Radiology Reports; Operative Reports; and/or Laboratory Reports

MEDICAL RECORDS REQUESTED FOR THE FOLLOWING:

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Revocation must be in writing. **This authorization will automatically expire 12 months from the date on which it is signed below.**

Waiver of Liability:

By signing this Consent, I agree to waive, release, and discharge HWLLC from any and all liability, including, without limitation, any injuries that may occur during the provision of services under this Consent.

By signing below, I am confirming that I understand the above disclosures, consent to the authorization to obtain needed information, and consent to treatment(s) (including vaccination(s), if applicable) that I will receive and/or that will be received by the minor named below for whom I attest that I am the parent, legal guardian, or authorized representative of and that I may provide effective consent for services at HWLLC.

In addition, I acknowledge that I have received the HWLLC Notice of Privacy Practices & Patient-Provider Policies.

Print Patient's Name: _____ Date of Birth: ____/ _____ / _____

Patient's/Representative's Signature: _____ Today's Date: _____

Print Representative's Name: _____

Print Mailing Address: _____

If signed by anyone other than the patient, indicate the relationship to the patient: ____ Parent ____ Guardian ____ Agent