

CONSENT FORM

Consent for Treatment: I consent to medical treatment of medical services performed or prescribed by the attending or consulting medical providers at Orchid Health, and I agree to the performance of treatments or procedures which are considered necessary, routine, or advisable. An example of some treatments performed at Orchid:

- Routine physical exams, including sports physicals
- Early detection, diagnosis and treatment of illness and injury treatment of minor injuries
- Assessment and management of chronic health conditions
- Age-appropriate reproductive health
- Routine lab tests and Immunizations
- Health education, counseling, and wellness promotion
- Prescription medications if appropriate
- Behavioral health services
- Referral for health care services not provided by Orchid Health

Authorization of Payment: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive. I also authorize the release of any medical records necessary to allow the insurance company to pay for these services, within the guidelines of the HIPAA (Privacy) Laws. I fully understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. If I do not have active insurance, I agree to pay for services at the time they are received.

Notice of Privacy Practices: I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice can be found on our website under patient forms, is available at the clinic upon check-in, and is otherwise available to me at any time upon request.

Patient Rights and Responsibilities: I acknowledge receipt of Orchid Health's Patient Rights and Responsibilities. These can be found on our website under patient forms, are available at the clinic upon check-in, and are otherwise available to me at any time upon request. I acknowledge receipt of information regarding Patient Rights and may accept or refuse care at any time. I understand I have the right to ask questions about and refuse these services. I acknowledge that I have the right to refuse care or withdraw my consent for care, without affecting my right to future care or treatment.

Consent to Access Historical Prescription/Pharmacy Records, and to Reach out to Local Hospital Networks to Access Health History Information: I authorize the release of my historical health information, as accurate information is necessary for the provision of accurate and quality medical care.

Consent to Call: I consent to receive calls from Orchid Health for my protected healthcare and other services at the phone number(s) provided to the practice, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Patient or Authorized Representative Name (Please print) _____

Date of Birth _____

If authorized representative, please state relationship to patient _____

Signature _____ Date _____