Health and Wellness Premium Services

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General Consent for Treatment

Consent for Treatment

I voluntarily consent to receive medical and/or mental health treatment at Health and Wellness Premium Services. This includes, but is not limited to, diagnostic procedures, therapeutic procedures, medical weight loss treatments, primary care services, mental health services, telehealth services, and any other procedures recommended by my provider(s).

Telehealth Services

Telehealth refers to the use of audio, video, or data communications to provide healthcare, including mental health services, remotely. You will engage in telehealth consultations where a designated healthcare practitioner will assess and discuss your condition via video or telephone.

Understanding of Risks

I understand that any medical or mental health treatment may involve risks, benefits, and possible complications, which will be explained to me by my provider. Telehealth involves specific risks, including:

- Interruption or distortion of data transmission.
- Unauthorized access to protected health information.

I have the right to ask questions and receive clear information about my treatment options, including telehealth.

Identity Verification

I understand that Health and Wellness Premium Services may require a copy of my driver?s license or other identity-verifying documents before health services are provided.

Confidentiality and Privacy

I understand that my medical and mental health records are confidential and will not be released without my written consent, except as required or permitted by law. All electronic communications will use reasonable measures to maintain confidentiality. I agree to secure my hardware and environment to protect my privacy during telehealth sessions. Confidentiality may be waived if unauthorized individuals are present at my location during sessions.

Treatment Plans

I understand that treatment plans are tailored to meet my individual needs and may require adjustments as necessary. I agree to follow my provider?s recommendations and participate actively in my care.

Right to Refuse or Withdraw Consent

I understand that I have the right to refuse any treatment or withdraw my consent at any time. If I choose to do so, I will inform my provider immediately.

Financial Responsibility

I acknowledge that I am financially responsible for all charges incurred during my treatment, including services not covered by my insurance or payment plan. If insurance coverage is available, I agree to provide all relevant insurance information and authorize them to bill my insurance provider on my behalf. I also agree to be responsible for any charges not covered by my insurance provider.

Provider Collaboration

I consent to allow providers at Health and Wellness Premium Services to collaborate and share relevant information as needed for my care.

Communication Interruptions

If technical issues disrupt a telehealth session, I will attempt reconnection within 5 minutes. For

unresolved issues, I will contact the main business number.

E-Mail and Text Messages

I understand that practitioners may use e-mail and text messages only for appointment arrangements. I agree not to send treatment-related questions via e-mail.

Audio and Video Recordings

I understand that sessions will not be recorded unless both parties agree in writing. I agree not to record sessions.

Client Location Requirements

I agree to be located within Florida during telehealth sessions and will refrain from driving during the session.

Discontinuing Telehealth Services

If telehealth is deemed ineffective, in-person services may be recommended. I may also request discontinuation of telehealth if it does not meet my needs.

Acknowledgment

Your electronic signature will have the same legal effect as a handwritten signature. I have read and understand this consent form. All questions have been answered to my satisfaction. I agree to the terms outlined above.

Patient Signature: _____ Date: _____

Printed Name: _____

Provider/Witness Signature: _____ Date: _____