



HIPAA Acknowledgment /General Consent for care and treatment

TO THE PATIENT: you have the right, as a patient, to be informed about your conditions and recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risk and hazards involved. At this time in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedures for identified condition(s).

At this time I consent for consultation, perform reasonable and necessary medical examination, testing in treatment for the condition, which has brought me to seek care at this practice. I do understand that an informed consent will be signed for specific procedures or if any additional special needs occur or an invasive interventional procedure is recommended.

I do give permission in case of a transfer or additional provider consults to share my HIV status (if available) and Psych history, additional to other information that the receiving facility requires, to help in my care. My signature gives my provider permission to obtain those tests.

I understand that I am responsible to pay for the services provided to me at the time of service.

If I have records available from prior births at the Birthing Center, Blessed Beginnings Care Center or New Eden Care Center, consent is implied to obtain those record if needed by my new provider.

I provide permission, in case of a transfer or additional provider consults, to share my HIV status and Psych history. Additionally, I understand that I required by my provider to get HIV/RPR and Rubella tested. My signature gives my provider the permission to obtain those tests and to share with other providers, if applicable to my care.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ❖ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- ❖ The day-to-day healthcare operations of your practice
- ❖ The Use of Electronic medical record that are passcode protected on a mobile device

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I understand that I am responsible to pay for the services provided to me at the time of service.

_____ Date _____

Patient

_____ Date _____

Witness