Telehealth Consent

This Telehealth Consent Form is designed to provide you with important information about the telehealth services offered by Kina Wellness. Please read the following information carefully and let us know if you have any questions or concerns.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to engage in telehealth consultations with KINA Wellness, a licensed healthcare professional. I understand that telehealth involves electronic communications for remote healthcare services, including videoconferencing, telephone consultations, and secure messaging.

I acknowledge the benefits of telehealth, such as increased access and convenience, but also recognize potential risks like technical issues, limited physical examinations, and the potential risk of unauthorized access to personal health information.

I understand KINA Wellness will take reasonable measures to ensure privacy and security during telehealth consultations. Confidentiality and privacy protections apply, and I consent to recording sessions only with explicit approval.

EMERGENT SITUATIONS: Emergency care will not be provided through KINA Wellness either in-person or via Telehealth Services. Contact emergency services in case of a medical emergency. In case of a medical emergency during our telehealth consult, I will contact emergency services immediately.

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| --- | --- | --- | --- |
| Patient's Signature: |  | Date: |  |

**If the Patient is a Minor:**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian Signature: |  |  |  |
| Relationship to Patient: |  |  |  |

General Consent

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to receive general medical care and treatment from KINA Wellness, a licensed healthcare professional. I understand that the nature of medical care may include, but is not limited to:

1. Physical examinations

2. Diagnostic tests

3. Medical procedures

4. Medications

5. Referrals to specialists

I acknowledge that the healthcare provider will discuss the proposed treatment plan, including potential risks, benefits, and alternatives. I understand that I have the right to ask questions and seek clarification about any aspect of my medical care.

I authorize KINA Wellness and its designated staff to access and disclose my medical information as necessary for the provision of healthcare services, including coordination of care with other healthcare providers.

I understand that while every effort will be made to ensure the privacy and security of my health information, no system is entirely free from the risk of unauthorized access.

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| --- | --- | --- | --- |
| Emergency Contact: |  | Phone: |  |
| Relationship: |  |  |  |

In case of a medical emergency, I authorize KINA Wellness to take any necessary and appropriate actions to ensure my well-being. If I am unable to make a decision, I trust KINA Wellness to consult with the emergency contacts listed above.

I am aware of the potential financial responsibilities associated with medical care and agree to fulfill any copayments, deductibles, or other fees as determined by my insurance coverage or payment arrangements.

I understand that I have the right to refuse or discontinue any part of the proposed medical care and that such decisions may have consequences for my health.

I have read and understood the information provided in this consent form. By signing below, I willingly consent to receive general medical care from KINA Wellness.

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| --- | --- | --- | --- |
| Patient's Signature: |  | Date: |  |

**If the Patient is a Minor:**

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Guardian Signature: |  |  |  |
| Relationship to Patient: |  |  |  |

HIPAA Compliance Patient Consent Form

 Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

* Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
* The practice reserves the right to change the privacy policy as allowed by law.
* The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
* The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
* The practice may condition receipt of treatment upon execution of this consent.

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| May we phone, email, or send a text to you to confirm appointments? |  | Yes |  | No |
| May we discuss your medical condition with any member of your family? |  | Yes |  | No |
| If yes, please name the allowed members: |  |  |  |  |
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| --- | --- | --- | --- |
| Patient's Signature: |  | Date: |  |
| Print Name: |  |  |  |