Just Living Healthcare
Home and Video Visits,
Anacortes, WA 98221

General Practice Agreements and Consents

Collaborative Care Consent

At Just Living Healthcare, we believe in a collaborative model of care which includes all pertinent care providers within your healthcare team. By signing below, you give us permission to contact your other care team members to inform them of your care with our practice as needed to ensure quality healthcare for you and your family. The signature below will act as permission for any minors under our care that you have guardianship for as well. You may revoke this consent in writing at any time, except to the extent that the organization has already taken action relying on this consent.

PATIENT SIGNATURE : ______________________________

Name of primary care provider (PCP) if you have one: * ______________________________

Name of any specialists that you see on a regular basis (midwife, ob/gyn, pediatrician, etc): * ______________________________

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Consent for Treatment:

You have the right, as a patient, to be informed about your condition and the 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 risks and hazards involved. At this point 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 procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the

right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Telehealth Consent for Treatment:
I understand that I may want to engage in a telehealth consultation through Just Living Healthcare.

My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE:
Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.

To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

Notice of HIPAA Privacy Policy:
I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. Obtain payment from designated third-party payers. Conduct normal health care operations such as quality assessments or evaluations and physician certifications. I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office or at this website: http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/notice.pdf).

I have had the opportunity to review such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have had the opportunity to study the Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is required to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

Advance Beneficiary Notice of Non-Coverage (ABN):

NOTE: If my insurance doesn't pay for my visit today, I will be required to pay the full balance of my visit.
Insurance coverage does not pay for everything, even some care that my health care provider and I have good reason to think that I need. By signing this form, I agree to allow Just Living Healthcare to bill my health insurance on file for the full cost of my healthcare. If I do not have insurance or if my insurance does not cover the cost of my visit, I understand that I will be responsible for full payment of the services rendered. I understand that I can choose not to sign this form and therefore not to receive healthcare at Just Living Healthcare. If I choose not to sign this form, I will not be responsible for payment and healthcare services will not be rendered. If I have insurance questions, I am aware that I can contact Just Living Healthcare at 360-328-1173 or info@justlivinghealthcare.com to discuss my patient bill and that payment plans are available if needed. I also confirm that I can contact my insurance carrier directly to confirm my coverage for healthcare services at Just Living Healthcare.

Additional Information: This notice will be used for all subsequent patient visits with Just Living Healthcare.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me.

That I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

PATIENT SIGNATURE : ______________________________

Please list any comments, questions or concerns if needed: ______________________________

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