Consent for Telehealth Services

SOLA HEALTH AND WELLNESS PLLC
Karnika Campbell, APRN, FNP-BC

Telehealth is typically an electronic transmission of data, using video calling, using technologies provided by the electronic health record, for improved patient access and convenience, which can result in a better patient care experience. During the communication, correct patient identification and confirmation of your practitioner and their credentials will be ensured. Telehealth does have some considerations:

The inability to have direct, physical contact with the patient is a primary difference between telehealth and direct in-person service delivery. The patient agrees that the practitioner determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter.

The knowledge, experiences, and qualifications of the EHR providing data and information to the provider of the telehealth services need not be completely known to and understood by the practice. Spruce does take active and layered security measures with the use of telemedicine technologies.

In addition, the quality of transmitted data may affect the quality of services provided by the provider. The patient agrees to hold the practitioner harmless for information lost due to technical failures.

The practice may, in some cases, be required to forward patient-identifiable information to a third party. This is not different than the requirements for other non-telehealth medical records.

I understand and agree with the above, and consent to using telehealth at SOLA Health and Wellness.

_____ _____

Patient (or Guardian) Signature Date

_____

Patient Printed Name

SOLA Health and Wellness PLLC

Consent to Treat and Consent to Obtain Prescription Information

Consent to Treatment

I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of SOLA Health and Wellness PLLC, its nurse practitioners and their designees, as many in their professional judgement are deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examinations or treatments on my condition or the condition of the persons whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the healthcare of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures. This consent may be revoked in writing at any time by the patient or duly authorized agent.

Consent to Obtain Prescription Information

I give SOLA Health and Wellness PLLC permission to access prescription medication information from all sources, such as pharmacies, insurance companies, and prescription monitoring databases.

Certification

I certify that I have read and that I understand the consent to treatment and consent to obtain prescription information given above and I accept their terms.

Name:_____

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

During your treatment at SOLA Health and Wellness PLLC, our caregivers may gather information about your medical history and current health. This Notice of Privacy Practices explains how that information may be used and shared with others. It also explains your privacy rights regarding this information.

SOLA Health and Wellness PLLC is required by law to abide by the terms of this notice, to make sure that information that identifies you is kept private, and to give you this notice of our legal duties and practices with respect to medical information about you.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION:

1. SOLA Health and Wellness PLLC may use or disclose health information to carry out treatment, payment and healthcare operations.
    - Treatment is the provision, coordination or management of healthcare. For example, we may use and disclose your information to consult with a third party or to refer you to other healthcare providers. We will get your written consent prior to making disclosures outside SOLA Health and Wellness PLLC for treatment purposes, except in emergencies.
    - Payment includes the activities necessary to obtain reimbursement for the provision of healthcare. For example, we may need to give your health plan information about treatment you received at SOLA Health and Wellness PLLC so your health plan will pay us or reimburse you for the treatment. We will get your written consent prior to making disclosures for payment purposes.
    - Healthcare operations include the activities necessary for SOLA Health and Wellness PLLC to run its business operations. For example, we may use your information to review treatment and services and to evaluate the performance of our staff.
2. We may use or disclose your health information:
    - When required by federal, state, or local law.
    - To support public health activities by reporting as required or authorized by state or federal law. These reports may include the reporting of exposure to a communicable disease or risk of spreading a disease or condition.

- To cooperate with law enforcement officials for certain law enforcement purposes as directed by a court order, warrant, criminal subpoena, or other lawful process.
- To report abuse or neglect.
- To support health oversight activities that are authorized by law, such as administrative or criminal investigations, inspections, licensure or disciplinary actions and other similar activities necessary for appropriate oversight of government benefit programs or functions.
- When required by a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as required by law.
- When necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, as consistent with applicable law and standards.
- For judicial or administrative proceedings, in a response to a valid court order, a grand jury subpoena, or with your written consent.
- For research purposes, with your written authorization or as permitted by state law.
- To business associates to perform functions on SOLA Health and Wellness PLLC behalf, if the business associate has signed an agreement to protect the confidentiality of the information.

3. We may disclose your health information to a family member, other relatives, or a close friend or any other person you identify if the information relates to that person's involvement in your healthcare if you consent to such a disclosure.
4. In other situations, your written authorization will be obtained before SOLA Health and Wellness PLLC will use or disclose your health information to third parties outside SOLA Health and Wellness PLLC.
5. State and federal laws may be more stringent and may prohibit certain uses and disclosures identified above. When another law is more stringent than the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), we will follow the more stringent requirements. For example, our state laws require additional protection for records related to mental health treatment, drug and alcohol treatment, and HIV-related information.

PATIENT RIGHTS:

1. You may request SOLA Health and Wellness PLLC to restrict uses and disclosures of your health information. However, SOLA Health and Wellness PLLC is not required to agree to the requested restriction. These requests should be made to the following email address:

info@solahealthandwellness.com

Requests must be made in writing. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit SOLA Health and Wellness PLLC's

use, disclosure, or both, and (c) to whom you want the limits to apply, for example, if you want to prohibit disclosures to your spouse.

2. You have the right to request confidential communications by alternative means or at alternative locations. For example, you may request that we communicate with you only by mail. We will accommodate all reasonable requests, but your request must specify how or where you wish to be contacted, and we may require you to provide information about how payment will be handled. You must request confidential communications in writing.
3. You have the right to inspect and obtain a copy of your health information that is used to make decisions about your care for as long as SOLA Health and Wellness PLLC maintains the information. This right does not apply to certain health information, including information compiled in reasonable anticipation of or for litigation and other information not subject to the right to access information under state law and HIPAA. Requests for access to health information should be made in writing to SOLA Health and Wellness PLLC. If access is denied, you will be provided with a written explanation that sets forth the basis for the denial, a description of how you may review those rights and a description of how you may review those rights and a description of how you may complain.
4. You have the right to request that SOLA Health and Wellness PLLC amend your health information if it is incorrect or incomplete. Requests for amendment of information should be made in writing to SOLA Health and Wellness PLLC, and you must provide a reason that supports your request to have the information amended. SOLA Health and Wellness PLLC may deny your request for an amendment if the request is not in writing and submitted to the office at the following email address: info@solahealthandwellness.com

5. In addition, we may deny your request if you ask us to amend information that: a) was not created by SOLA Health and Wellness PLLC; b) is not part of the medical information kept by SOLA Health and Wellness PLLC; c) is not part of the information you would be permitted to inspect and copy; or d) is accurate and complete.
6. At your request, SOLA Health and Wellness PLLC will provide you with an accounting of disclosures by SOLA Health and Wellness PLLC of your health information. However, such accounting will not include disclosures made: 1) to carry out treatment, payment or healthcare operations; 2) directly to you or your personal representatives; 3) prior to the effective date of this notice; or 4) based on your written authorization. Requests for a request of an accounting of disclosures should be made in writing to:
   info@solahealthandwellness.com

7. You may exercise your rights through a personal representative as permitted or required by applicable law. Your personal representative may be required to produce evidence of authority to act on your behalf before that person will be given access to your information or allowed to take any action for you.
8. If you believe your privacy rights have been violated you may complain to the office of SOLA Health and Wellness PLLC and/or you may file a complaint with the Secretary of the US Department of Health and Human Services. SOLA Health and Wellness PLLC will not retaliate against you for filing a complaint.

SOLA HEALTH AND WELNESS DUTIES

This notice is effective beginning February 22, 2022. However, SOLA Health and Wellness PLLC reserves the right to change its privacy practices and this notice, and to apply the changes to any health information received or maintained by SOLA Health and Wellness PLLC prior to the date of the changes. If the terms of this notice are changed, a revised version will be available upon request and will be posted in a clear and prominent location in the clinic. You may also access this notice at anytime by visiting our website at www.solahealthandwellness.com.

Complaints, Questions, and Requests

You may direct your questions about this notice or SOLA Health and Wellness PLLC's privacy practices, requests regarding your information, or other privacy or confidentiality concerns to:

info@solahealthandwellness.com

You may also direct complaints regarding this notice or SOLA Health and Wellness PLLC's privacy practices, requests regarding your information, or other privacy or confidentiality concerns to the Office of Civil Rights, US Department of Health and Human Services.

All complaints should be submitted in writing. You will not be penalized for filing a complaint.

PATIENT REGISTRATION

Patient Information

Patient Name: (Last, First, Middle Initial)	Gender:	Date of Birth:	Social Security #:
Mailing Address: (Street / Apt. / PO Box)	City	State	Zip Code
Home Phone:	Work Phone:	Cell Phone:	Email:
Employer:	Occupation:	Emergency Contact Name:	
Marital Status: ◉ Single ○ Married ○ Separated ○ Divorced ○ Partnered x _____ years		Emergency Contact Phone:	
Who completed this form? ○ Patient ○ Family Member (*Parent,sibling etc.*) _____ ○ Partner ○ Guardian		Emergency Contact Relationship:	
How would you like to be contacted? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Voicemail		How did you hear about us?	

Insurance Information

Primary Insurance:		Secondary Insurance:	
ID#:	Group#:	ID#:	Group#:
Name of person responsible for the account:	Phone:	Relationship to patient:	

Health Provider Information

Name of primary care physician or medical provider:	Date last seen:	Phone number:
Address:		Fax number:

Current Medications

Medication name, dosage, and reason for taking:	Medication name, dosage and reason for taking:
Medication name, dosage and reason for taking:	Medication name, dosage and reason for taking:
Medication name, dosage and reason for taking:	Medication name, dosage, and reason for taking:

Social History

Do you drink alcohol?	Do you use recreational drugs?	Do you use tobacco products?
◉ No alcohol use ◯ Less than 2 drinks weekly ◯ 1-2 drinks daily ◯ More than 2 drinks daily	Type:_____ Frequency:_____	Type:_____ Frequency:_____ O Former Smoker
Do you feel safe at home?	Do you live alone?	Do you drink caffeinated beverages?
◯ Yes ◉ No	◯ Yes ◉ No	Frequency:_____

Family History (check all that apply)

	Mother	Father	Brother	Sister	Other		Mother	Father	Brother	Sister	Other
Diabetes	☐	☐	☐	☐	☐	Thyroid Disease	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	Arthritis	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	Asthma	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	Other	☐	☐	☐	☐	☐

Please provide details or list other chronic conditions:

Past Hospitalizations/Surgeries/Where Performed

1.	Date:	2.	Date:
3.	Date:	4.	Date:

Allergies

☐ (check) I have no known drug allergies

I am allergic to:	I have the following reaction:	I am allergic to:	I have the following reaction:
1.		3.	
2.		4.	

Female Patients

Date of last pelvic exam:	Date of last pap smear:	Abnormal pap smear? ☐ Yes ☐ No	No. of Pregnancies?
Date of last mammogram:	Date last menstrual period onset:	Possibly pregnant? ☐ Yes ☐ No	Colonoscopy? ☐ Yes ☐ No

Male Patients

Date of last prostate exam:	Abnormal prostate exam: ☐ Yes ☐ No	Colonoscopy? ☐ Yes ☐ No

Immunizations/Vaccines (indicate date if known)

	Influenza	Hep B	Hep A	Measles	BCG or Pos PPD	Tetanus	Polio	Shingles	Pneumonia
Yes									
No									
Not Sure									

Health History

Please indicate conditions you presently have OR have had in the past.

Cancer

Type:

Cardiovascular Problems

- ☐ stroke
- ☐ chest pain
- ☐ irregular heartbeat
- ☐ high blood pressure
- ☐ hardening arteries
- ☐ heart murmur
- ☐ other heart condition

Neurologic Problems

- ☐ headaches
- ☐ head injury
- ☐ convulsions/seizures
- ☐ paralysis of limbs
- ☐ multiple sclerosis

Ears, Nose, Mouth, Throat

- ☐ ear trouble
- ☐ decreased hearing
- ☐ sinus trouble
- ☐ strep throat history

Gastrointestinal

- ☐ stomach
- ☐ acid reflux GERD
- ☐ diverticulitis
- ☐ colitis/Crohn's
- ☐ other bowel problems
- ☐ liver trouble
- ☐ gall bladder trouble
- ☐ hernia
- ☐ hemorrhoids

Skin Problems

- ☐ skin infections
- ☐ skin lesions
- ☐ eczema
- ☐ psoriasis
- ☐ recent tattoos
- ☐ other

Endocrine

- ☐ thyroid disease
- ☐ diabetes
- ☐ insulin dependent

Respiratory

- ☐ shortness of breath
- ☐ bronchitis
- ☐ emphysema/COPD
- ☐ pneumonia
- ☐ allergies
- ☐ asthma
- ☐ tuberculosis or exposure
- ☐ other lung problems:

_____

Eyes

- ☐ wear glasses/contacts
- ☐ eye or eye lid infection
- ☐ glaucoma
- ☐ other eye problems

Musculoskeletal

- ☐ arthritis
- ☐ rheumatoid arthritis
- ☐ bone/joint infection
- ☐ artificial joint
- ☐ bone tumor/cyst
- ☐ gout

Genitourinary

- ☐ kidney disease
- ☐ prostate
- ☐ bladder disease
- ☐ gonorrhea, syphilis, herpes (please circle)
- ☐ loss of bowel or Bladder control

Hematologic/Lymphatic

- ☐ bleeding/bruising
- ☐ blood clotting prblms.
- ☐ anemia
- ☐ phlebitis
- ☐ hepatitis

Type_____

Psychiatric

- ☐ mental problems
- ☐ nervous breakdown
- ☐ depression
- ☐ bipolar
- ☐ other

_____

Other

- ☐ migraines
- ☐ HIV
- ☐ Lupus

Patient Consent for Services, Use and Disclosure of Protected Health Information

I CONSENT (AGREE) TO MEDICAL SERVICES: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the service practitioner to whom I have been referred. I will ask for any information I want to have about my services and will make my wishes known to the practitioners and/or staff.

I hereby give my consent for **SOLA Health and Wellness PLLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **SOLA Health and Wellness PLLC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **SOLA Health and Wellness PLLC** reserve the right to revise its Notice of Privacy Practices at any time.

With this consent, **SOLA Health and Wellness PLLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **SOLA Health and Wellness PLLC** may send e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **SOLA Health and Wellness PLLC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **SOLA Health and Wellness PLLC** may decline to provide treatment to me.

By signing below, I am confirming that I understand the information above and that I consent to the disclosures described.

_____	_____	_____
Patient Name	Signature	Date

If signed by anyone other than the patient, please indicate which of the following describes the relationship to the patient:

Parent/Guardian Health Care Agent Other_____

Notice of Privacy Practices: I acknowledge that I have received the Clinic's Notice of Privacy Practices

PATIENT RESPONSIBILITIES

- It is your responsibility to provide accurate and complete information about all matters pertaining to your health, including medications and past or present medical problems.
- You are responsible for following the instructions and advice of your healthcare provider. If you refuse treatment or do not follow the instructions or advice, you must accept the consequences of your actions.
- It is your responsibility to notify a member of your healthcare team if you do not understand information about your care and treatment.
- You are responsible for reporting changes in your condition or symptoms, including pain, to your healthcare provider.
- It is your responsibility to act in a considerate and cooperative manner and to respect the rights and property of staff and other patients/visitors of this clinic.
- You are expected to keep your scheduled appointments or to cancel them in advance if at all possible.
- It is your responsibility to pay your bills or make advance arrangements with this healthcare clinic to meet your financial needs.

PATIENT RIGHTS

- You have the right to considerate and respectful care.
- You have the right to participate in the development and implementation of your plan of care.
- You will not be denied access to care due to race, creed, color, national origin, sex, age, sexual orientation, disability or source of payment.
- You have the right to information about your diagnosis, condition and treatment in terms that you can understand.
- You have the right to refuse treatment and to be informed of the possible consequences of the refusal.
- You are entitled to be free from all forms of abuse or harassment.
- You have the right to personal privacy and to receive care in a safe environment.
- You have the right to a prompt and reasonable response to any request for services within the capacity of this healthcare facility.
- You have the right to express concerns or grievances regarding your care to the clinic staff or to governing local/state/federal agencies.
- The confidentiality of your clinical and personal records will be maintained.
- You have the right to see and receive copies of your medical record within the limits of the law**.**