



## **PATIENT CONSENT AND AUTHORIZATION FOR TREATMENT**

I, the undersigned am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Family First Wellness Center (FFWC) through its individual physicians, employees, and/or agents. Such care may include, but not be limited to, diagnostic procedures, other treatments and medications, and procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantees can be made or have been made as to results of treatments or examinations at FFWC.

**Communication:** I authorize FFWC to Communicate information about my condition and treatment to designated personnel as per privacy practice policies.

**Procedures:** I consent to medical procedures rendered by my physician within the scope of standard Family Medicine services. Additional procedural consent will be obtained per state law requirements when necessary.

**Teaching:** I understand that FFWC is a teaching center and I may come into contact with medical trainees. I reserve the right to refuse when necessary.

**Technology:** I consent to the use of electronic communication technologies in the delivery of my healthcare services. These technologies may include, but are not limited to, telehealth visits, patient portals, electronic kiosks, text messaging, and other digital communication methods.

I understand that the use of electronic communication may involve certain risks, including potential limitations in privacy and security, despite reasonable safeguards in place. I acknowledge that these technologies are used in accordance with applicable state and federal privacy and security standards. I understand that my participation is voluntary and that I may refuse or withdraw my consent for the use of these technologies at any time, without affecting my right to receive care.

In consideration of services provided by FFWC, I hereby assign and transfer to FFWC any and all rights, entitlement and interest in all benefits and payments now due and payable, or that become due and payable, under any insurance policies, any replacement policies, any self-insurance program, employers and state welfare funds, or under any other benefit or entitlement plan. I authorize the release of any medical information deemed necessary by FFWC or its agents or divisions to my insurance carrier or any entitlement program provider in order to determine the benefits applicable to this date of service. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that I am financially responsible for all charges, whether or not they are covered by my insurance carrier or entitlement plan, including Medicare. I understand that I am responsible for paying any co-payment or deductible amounts at each clinic visit.

I acknowledge that I have received Family First Wellness Center's Notice of Privacy Practices & Welcome Packet and consent to treatment. I confirm that I have read, or have had this form read to me, and all questions related to this form have been answered by FFWC providers.

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***Patient Name (please print)***

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***Date of Birth***

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***Signature***

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***Date***

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***Relationship to patient, if consent not signed by patient***

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***Telephone Number***