PATIENT CONSENTS AND ACKNOWLEDGEMENTS

1. Notice of Privacy Practices

Initials: _____

I acknowledge that I have received the practice's Notice of Privacy which describes the ways in which the practice may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Compliance Officer if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy. These documents are posted in the lobby. I acknowledge that I have received a copy of each.

(This section is for CAN office staff usage only): Good Faith Effort

The following good faith efforts were made to obtain the individual's or representative's signature on (date):_____

☐Face to Presentation ☐Telephone Contact ☐Mailing ☐Email ☐Other: _____

Staff Signature: _____

2. Patient Portal

Initials: _____

Our patient portal allows you confidential, 24-hour access to your medical records and allows patients to communicate with our practice in a convenient, safe and secure way. After signing up, you will have the ability to submit refill requests, send messages to the nursing department, update personal information as needed, and review upcoming appointments. Provide an email and get signed up today! **CAN Community Health, Inc. (CAN)** offers a secure and easy online payment option for the portion of services that your insurance does not cover. Payment can be made online in your patient portal. Your credit card information will not be saved by CAN.

3. Telehealth

Initials: _____

I understand that it may be necessary to schedule visits with a CAN Community Health, Inc. provider on a telehealth platform. For a telehealth appointment I will ensure I have a secure, private location with reliable internet access and plan to arrive 15 minutes prior to my appointment time to login work though any technical issues that I may have. I will be responsible for any co-pays. I understand that my provider is licensed in the state I am registered to receive services and the laws of the state in which I am located will apply to my receipt of telehealth services.

- Potential benefits of telehealth (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my CAN provider's office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location.
- Potential risks of telehealth include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold CAN responsible for lost information due to technological failures.

4. No Show Policy

Initials: _____

Because we reserve a considerable amount of physician and staff time for your healthcare needs, we require at least 24 hours' notice when rescheduling or cancelling your appointment.

- Failure to provide at least 24 hours advance notice may result in a $35 no show fee. You will be required to pay any no show fees prior to your next visit or work out a payment plan with a financial counselor if charged a no-show fee.
- If you have two no shows within a 12-month period, you may be required to schedule during one of our designated no show clinic openings to see one of our doctors. Multiple no shows may result in dismissal from the practice.
- Reminders are provided via the phone number you provided as courtesy ahead of your scheduled appointment date. Let us know immediately if you contact information changes. Please consider signing up for our confidential patient portal (see number 2), which allows you to easily update your information.
- If you need to reschedule or cancel your appointment, please call (844) 922-2777 and dial prompt 3 for scheduling.

This Section is for Office Use ONLY

Patient Name:_____

Pt DOB: _____

Pt ID#:_____

COMMUNITY HEALTH

5. Consent for Use and Disclosure of Protected Health Information (PHI) **Initials:**_____

- May we call your job and leave a message? ☐Yes ☐No
  If yes, at that phone number?_____
- May we call your home and leave a message? ☐Yes ☐No
  If yes, at what phone number?_____
- May we leave a message concerning medical information on your cell phone? ☐Yes ☐No
  If yes, at what phone number?_____

6. Consent to Email or Text Message for Appointment Reminders and Other Healthcare Communications **Initials:** _____

- **Part 1: Consent to Email/Text**

Patients in our practice may be contacted via email and/or text messaging for appointment reminders and general health information. If at any time I, the patient, provide an email or mobile number at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or mobile number from the practice. I consent to and accept the risk in receiving appointment/information via email or text message.

Emails and text messages will be part of your medical record -we will use the minimum amount of information necessary in any communication. Please check off the appropriate boxes and complete as needed.

☐ **I consent** to receive **TEXT** messages for appointment reminders, feedback, and general health reminders/information at this mobile number: _____

☐ **I consent** to receive **EMAIL** messages for appointments reminders, feedback, and general health reminders/information at this email: _____

If you, as the patient, sends an email or text message to CAN Community Health, Inc., CAN will take that as permission to correspond via email or text message. Our reply will explain that emails are not secure and request that you sign this form the next time you are in the office. I, the patient, understand that I can change my mind at any time and provide consent later.

- **Part 2: Revocation If You Do Not Want to Receive Email/Text**

☐ **I do NOT** consent and hereby revoke my request to receive **EMAIL** messages for appointment reminders, feedback, and general health reminders/information

☐ **I do NOT** consent and hereby revoke my request to receive **TEXT** messages for appointment reminders, feedback, and general health reminders/information

_____ _____

Patient or Parent/Guardian Signature Date

_____ _____

Patient or Parent/Guardian Signature **Date**

This Section is for Office Use ONLY

Patient Name:_____

Pt DOB: _____

Pt ID#:_____

Last Revised 01/13/2021