

PRIMARY CARE, BEHAVIORAL HEALTH, AND DENTAL TREATMENT

Elevated Community Health provides treatment and care through an integrated model. We provide whole person care through a care team which includes various aspects of physical, behavioral, and dental health services.

I **voluntarily** consent to in-person and/or telehealth primary care, dental and/or behavioral health treatment, diagnostic testing, examination, administration of medication, immunizations, and other medically necessary health care services that focus on my health care needs determined by my care team. I understand that this authorization applies to routine, urgent, chronic medical, behavioral, and dental health services provided at Elevated Community Health (ECH). The services authorized by this consent include those provided by ECH's medical staff providers to include physicians, clinical pharmacists, nurse practitioners, physician assistants, nurses, health educators, medical assistants, and medical technologists. Dental providers include dentists, dental assistants, and dental hygienists. Behavioral health providers include licensed psychologists, social workers, counselors, and registered psychotherapists. I also consent to treatment by health professionals in training under the supervision of a licensed health care professional.

I understand that ECH empowers and encourages me to ask questions regarding my care and any potential risks and/or benefits regarding testing or treatment. I understand that I have the right to refuse treatment at any time.

I authorize ECH and its related entities, agents, and contractors to receive/send messages including but not limited to SMS text messages, voice messages, and/or emails to me. Messages may include appointment reminders, post-visit surveys, payment due dates, missed payments, missed appointments, information related for or related to medical goods and/or services provided, care follow-up, and other health care information. I also understand that charges from my cell phone carrier may apply. I am aware that I may opt-out of SMS text messages by contacting ECH.

I authorize payment of benefits to ECH for services rendered. I understand that I am financially responsible for services not covered by my insurance, other third-party payors, or discount programs offered by ECH. Additionally, I agree to pay all balances due and understand that an unpaid balance may be referred to a collection agency following four consecutive months of non-payment.

I UNDERSTAND that the protection and privacy of patients, staff, and guests are of the utmost importance to ECH and acknowledge that ECH will keep my records confidential. The release of any protected health information will require my consent unless permitted under the HIPAA and/or 42 CFR Part 2. I also extend my respect to ECH and understand that ECH prohibits the use of audio and video recording within any ECH location.

Printed Name of Patient: _____ Patients Date of Birth: _____

Signature: _____ Date: _____
Patient/Legal Guardian

Printed Name of Legal Guardian: _____ Relationship to Patient: _____