GENERAL CONSENT TO TREAT

You hereby authorize all medical staff at Agile Providers to render medical evaluations, vaccinations, screenings, medical procedures and care to you or to the patient indicated below.

You have the right to discuss any cultural, religious, spiritual or other preferences that may impact your visit or treatment plan. If you have any communication or language barriers, notify your provider.

Agile Providers may use or release your health information to other healthcare providers and their staff for treatment purposes, to third party payers and other third parties as necessary for Agile Providers to obtain payment for services you have received. Agile Providers will request your medication prescription history from other healthcare providers or third party pharmacy benefit managers. Agile Providers may also see to obtain your electronic health record information from other providers or through Health Information Exchanges in order to provide healthcare services to you. Additional information regarding the use and disclosure of your health information can be found in the Notice of Privacy Practices. Please let your provider know if you have any questions or concerns.

You hereby authorize all medical staff at Agile Providers to contact you via your email or text message to confirm appointments or send receipt of payment for services. Agile Providers may also contact you via telephone and leave a voice message to confirm appointments, follow up visit calls, or to discuss lab results.

By signing below, I am the patient confirming that I understand the above disclosures and consent to the treatment that I or the patient named below for whom I attest that I am the parent, legal guardian or authorized representative of and that I may provide consent for this service. I acknowledge I have received a copy of the Notice of Privacy Practices. I have read and understand the Notice of Privacy Practices, I was given the opportunity to discuss it with the medical provider, and all of my questions have been answered to my satisfaction. My typed name may serve as my signature.

AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with Agile Providers.
1) Purpose and Benefits. Improve access to medical care by enabling a patient to remain in his/her home to decrease risk of exposure to illnesses and to decrease risk of exposing illness to the community. At present time, the community is performing social distancing and containment at home due to the current COVID-19 pandemic; as advised by the Governor of Virginia declaring state of emergency on March 12, 2020.
2) During the telemedicine consultation: Details of your medical history, examinations, and tests will be discussed with the Nurse Practitioner through the use of interactive video, audio and telecommunications technology. Physical examination of you may take place.
c) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.
3) The patient is aware that a telemedicine consultation may not be able to offer the same type of service that they would receive at an in-person appointment.

By signing this form, I understand the following:
1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that my information is governed by Agile Providers Notice of Privacy Practices.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or
treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. The medical provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform the medical provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I understand that a telemedicine visit may not be able to offer the same type of service as an in person visit.

I have read and understand the information provided above regarding telemedicine, have discussed it with the Nurse Practitioner, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I hereby authorize the use of telemedicine in the course of my diagnosis and treatment. My typed name may serve as my signature.

______________________________ ______________________________ ________________
Patient Name Patient Signature Date

______________________________ ______________________________
Patient under 18 years old, Parent/Legal Guardian Name Parent/Legal Guardian Signature

____
Address City State Zip code

______________________________ ______________________________
Telephone Number Date of Birth

____
Email Address