Elessar Psychiatry, PLLC
169 W 2710 S Circle Ste 202a
St George, UT 84790
admin@elessar.care
Cell 720.664.9877 | Fax 888.350.9528

CONSENT TO TREAT

As the patient – or as the personal representative of the patient – I consent to the terms and conditions of this agreement. By signing below, I intend that the following apply to all my outpatient care and services provided by Elessar Psychiatry. The terms "I," "my," and "you" in this agreement refer to the patient and to their authorized agent or legal representative.

Consent for healthcare services

1. I consent to healthcare services provided by Elessar Psychiatry. This includes services I receive provided by Elessar Psychiatry employees, medical staff, and independent contractors. Healthcare services include all healthcare and related medical, diagnostic, and therapeutic services, the implementing of physician orders, and all tests, studies, treatments and procedures ordered and performed in the good faith belief that they are either medically necessary or otherwise appropriate for me under the circumstances. I may be asked to give additional consent for procedures, tests, or treatments that have additional risk.
2. I understand that:
    a. My care is under the supervision and control of my attending/treating physician(s) and health care providers such as physician assistants or nurse practitioners (collectively "Clinicians"), as allowed by law.
    b. All healthcare services come with some risk, sometimes even the risk of serious harm. I accept this risk in the hope of a good result.
    c. No promise has been made to me concerning a final result, outcome, or cure.
    d. Healthcare provider training may occur during my care. Any care provided by a trainee will be under the supervision of my clinicians or healthcare team.
    e. I can change my mind or refuse care. If I do, I must tell my healthcare team as soon as possible.

Independent contractors

3. I understand that some of the people providing my care may be independent contractors and not employees or agents of Elessar Psychiatry. I understand that:
    a. Elessar Psychiatry is not responsible or liable for the judgment, conduct, actions, or inactions of independent contractors.
    b. Some of these people may be government employees or otherwise subject to governmental immunity laws.

My protected health information

4. Elessar Psychiatry will keep medical records about me confidential, as required by state and federal laws. I have been offered a copy of Elessar Psychiatry's Notice of Privacy Practices, which describes

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how medical information about me may be used and shared and my rights including how I can get access to this information. It may be revised from time to time, and I may ask to see a copy at any time.

5. The use of patient identification photographs for medical records includes recording and saving images in the print and/or digital records and identification of patients.
    a. I have been provided the opportunity to ask questions concerning patient identification photography and understand that refusal to consent will not affect my medical care.
    b. I consent to my photograph being taken, stored within my electronic medical record and used for clinical purposes and identification.
6. I consent for my health information to be accessed by anyone at Elessar Psychiatry, or its subcontractors, needing it for treatment, payment, or healthcare operations, without further approval from me.
7. I understand that Behavioral health Progress Notes for psychotherapy services are documented in the medical record and do not meet the definition of Psychotherapy Notes under the HIPAA Privacy Rule. Behavioral health Progress Notes are subject to the same requirements and protections as other medical information. Please see Elessar Psychiatry Health's Notice of Privacy Practices for additional information.
8. I understand that my health providers may disclose my protected health information when they have a reasonable belief that I may be a serious and imminent danger to myself or someone else. They can disclose necessary information to any person who can lessen the risk, including my family, friends, or law enforcement.
9. I understand that if I pose an actual threat of physical violence against a clearly identified or reasonably identifiable victim, then my health provider may disclose my protected health information to law enforcement and the potential victim.
10. Disclosure of my Federal Social Security Number in reference to Medical Devices is required by the FDA under the Safe Medical Devices Act of 1990 and also for other state and federally mandated requests.

Common Use of Health Information

11. When we care for you, we will gather your health information. The law allows us to use or share this health information to participate in health information exchanges, which are secure computer networks that provide safe and efficient ways to share medical information with other health care providers.
12. I understand that:
    a. By participating in this network and other electronic information exchanges, we intend to provide timely information to health care providers involved in your care.
    b. Providers at other health care facilities could have access to your medical information to assist them in caring for you. For example, if you require emergency medical care while you are traveling, providers where you receive services could have access to your medical information.

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13. **Other Permitted and Required Uses and Disclosures** Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

14. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
15. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this

Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

    a. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

16. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
17. You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of a disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
18. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Telehealth

19. I understand that I may receive care from healthcare providers at other locations using telehealth technology. In receiving telehealth services, I understand that:
    a. Elessar Psychiatry safeguards medical information about me used in telehealth services, and only uses and shares this information as described in Elessar Psychiatry’s Notice of Privacy Practices.

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b. The technology used to deliver telehealth services meets industry security and privacy standards.
c. This technology could fail resulting in lost information and potential exposure of my health information notwithstanding the security measures in place.

Photographs and audio and video recording

20. I understand that Elessar Psychiatry has the right to take photos or video for security purposes, to help with my care, for educational training purposes, or to improve quality of care.
21. I agree that I will not take pictures, videos, or audio recordings in Elessar Psychiatry facilities without first obtaining the permission of everyone in the image, video, or recording. I understand that employees, providers, and others have the right to refuse to be included in an image, video, or audio recording.

What I am responsible to pay

22. I, as the patient or as a person signing for the patient who is otherwise legally responsible to pay for the care of the patient (the "Responsible Party"), agree to pay for the following charges:
    All amounts owed for healthcare services I receive from Elessar Psychiatry, as determined by Elessar Psychiatry or an independent contractor.
    a. My share of the costs, including all co-payments, deductibles, and co-insurances that apply.
    b. All charges for non-covered services.
    c. All costs and attorney fees (if used) Elessar Psychiatry or an independent contractor incurs if either refers my overdue bill for collection.
    d. If I am the Responsible Party, I hereby consent to credit bureau inquiries for Elessar Psychiatry Health's or the independent contractor's business needs, including any account management companies and debt collectors.

Consent for Text, Digital, and Email Communications

23. I hereby consent to receiving text, digital, and email communications (including auto-dialed, artificial, and pre-recorded messages and calls) to my cellular phone number, email address, and any other telephone numbers provided during any interaction, agreement or communication with the Elessar Psychiatry, the independent contractor, or their affiliates, agents and contractors. I acknowledge that text and email communications are not a secure method of communication and accept the risk that my information may be intercepted and read by a third party.

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Changes to this consent

24. If I make changes to this consent document, they are not valid.

By signing below, I understand and agree to the following:

a. I have had the opportunity to read this agreement or have it read to me and I understand what I am agreeing to.
b. I have had the opportunity to ask questions regarding this agreement and I have received satisfactory answers to all my questions regarding this document.
c. I can ask for and get a copy of this agreement.
d. This document will remain in effect unless I revoke it in writing.
e. I hereby authorize Elessar Psychiatry to use telemedicine in the course of my diagnosis and treatment.

_____

Patient/Guardian/Personal Representative's **SIGNATURE** Relationship (if not patient) Date

_____

Guardian/Personal Representative's **PRINTED** Name