**Consent for Medical Treatment**

This form includes important information about how care is provided to patients at Better You Virtual Health (BYVH). Patients, parents, guardians, and other patient representatives should read this information carefully or ask for assistance to have the form read to you. By signing this form, you agree to receive care at BYVH according to the following terms and conditions:

1**. Consent**. I request and authorize Better You Virtual Health and its practice providers and designees to provide the medical care and treatment necessary or advisable to me, or the patient identified below. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care.

2. **Emergencies**. I authorize Better You Virtual Health to perform other additional or extended services in emergency situations if it may be necessary or advisable to preserve my, or the patient’s, life, or health.

3. **Risks and Benefits**. I am aware that the practice of medicine is not an exact science and I understand that Better You Virtual Health is not making any guarantees or promises about the results of the care received.

4. **Health Changes**. I understand that it is my responsibility to tell the practice providers if there are any significant change in my, or the patient’s physical or emotional condition.

5. **Testing**. I understand that samples of body fluids and/or tissues may be withdrawn during tests and procedures. I authorize Better You Virtual Health and its affiliates to perform other tests on these body fluids and/or tissues to further treatment and/or to dispose of these fluids and tissues.

6. **Medication Verification**. I authorize Better You Virtual Health to contact healthcare providers from whom I, or the patient, have received treatment to obtain medical information and/or records, including but not limited to, commercial pharmacies (i.e. Walgreens, CVS, Costco, etc.), and alcohol and other drug treatment records for verification of my medications and treatment.

7. **Transmittable Diseases**. I have been informed and understand that HIV (human immunodeficiency virus)/AIDS, HCV (hepatitis C virus) and HbsAg (hepatitis-B virus) tests may be performed on me, or the patient, without my consent if a health professional, facility employee or First Responder sustains an exposure to my, or the patient’s, blood, or other body fluid.

8. **Personal Valuables**. I understand that I am responsible for all personal valuables that I bring with me, or the patient, to the office. I hereby release BYVH/ Rhonda Anthony, FNP-BC

and its agents from any liability for the loss or damage of all personal possessions which I choose to keep with me during my, or the patient’s, care and treatment.

9. **Acknowledgement of Privacy Practices**. The Better You Virtual Health’s Notice of Privacy Practices provides information about how protected health information about patients may be used or disclosed for purposes of treatment, payment, or the office operations. Information about communicable diseases and infections, including venereal disease, tuberculosis, hepatitis B, HIV (AIDS virus) and AIDS related complex, alcohol and drug abuse treatment information, mental health treatment records, and reports of abuse, abandonment or neglect may be used and disclosed under certain circumstances. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Privacy Notice may change and that I may request a current copy from the Health Center at any time.

11. **Attendance Policy**. A copy of the No Show Policy has been made available to me. I understand it is my responsibility to know my, or the patient’s, appointment dates and times and I understand that services may be discontinued in the event I, or the patient, do not attend scheduled appointments.

12. **Ending Treatment**. I understand that I have the right to terminate treatment at Better You Virtual Health PLLC at any time I choose to do. I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS, AND HAVE THESE QUESTIONS ANSWERED. \_ Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Legal Guardian if Patient is a Minor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_

Print Guardian Name Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_