Welcome to ThriveWell Clinic. We are committed to giving you the best care possible and would like to take this opportunity to inform you of our office policies and obtain your consent for the following:

Consent for Treatment: By signing this document, I do hereby request and authorize ThriveWell Clinic (TWC), its medical practices and providers including physicians, technicians, nurses, and other qualified personnel, including appropriately supervised students and residents to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures. **TREATMENT OF MINOR CHILDREN:** I understand patients under the age of 18 must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at time of service(s) regardless of court-ordered responsibility.

Insurance Authorization and Assignment: I request that payment of authorized medical benefits is made on my behalf directly to the TWC provider of service(s) furnished to me. I authorize TWC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to TWC. I hereby authorize that photocopies of this form to be valid as the original.

Self-Pay Patients: I understand if I do not have active coverage or choose not to utilize my insurance benefits, I responsible for all charges occurred at time of service.

Payment Guarantee: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through TWC medical practices and providers from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a TWC billing statement whether it is an interim or final bill. In the event that I fail to make full payment or fail to comply with other payment arrangements made with TWC's approval, I understand that appropriate collection measures may be initiated.

Restricted Service: I understand that all account balances must be in good standing prior to receiving additional services and will contact TWC's staff if I am unable to pay my balance. Past Due Accounts of 60 days or longer may be turned over to a third-party for collection, along with collection costs, attorneys' fees and court fees. I also understand I may be discharged from the practice.

Late Policy: I understand that if I am more than 10 minutes late I will be asked to reschedule my appointment.

Returned Checks: I understand that there will be a $25 fee assessment for returned checks for non-sufficient funds, stop payments, and account closures. My account will be flagged for failure to pay and checks will no longer be accepted as a form of payment for my account.

Appointment Cancellation and No Shows: We will attempt to contact you for appointment reminders; however, it is my responsibility to arrive for my appointment on time. I will notify TWC at least 24 hours in advance to cancel and/or reschedule my appointment.

Prescription Refills: I understand that TWC requires office visits on a regular basis for all patients taking prescription medications. I understand that TWC requires at least 2 business days for refill requests to be addressed.

Referrals: I understand that all referrals will require an evaluation in the office. I understand that if my insurance requires an authorization it will take 5-7 business days for referral to be completed.

Disability, Family Medical Leave Act (FMLA) Paperwork and Other Forms: I understand that all forms requiring a provider signature require an office visit.

Electronic Health Record: I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE). TWC will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records.

If I have provided my e-mail address, I am requesting the ability to access my medical information through the ThriveWell Clinic on-line Patient Portal.

Electronic Prescribing: I understand that TWC uses an electronic prescription system which allows prescriptions and related information to be electronically sent between my TWC providers and my pharmacy. I have been informed and understand that TWC providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my TWC providers to see this health information.

Consent for Telemedicine Services: I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider

and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Immunization Registry: I understand that TWC participates in the Oregon Health Authority's statewide immunization registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

Cell Phones: I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the TWC, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by HIPAA secure texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

Notice of Privacy Practices: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of TWC's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all my protected health information generated during treatment at TWC, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy if requested. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

____ Patient/Guarantor Name (please print)

____ Signature of Patient/Guarantor