If I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION (HIPPA)

Use and Disclosure of your protected health care information will be used by Accuhealth and Accucare of Texas or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

NOTICE OF PRIVACY PRACTICES

You should review the NOTICE OF PRIVACY PRACTICES for a more complete description of how your Protected Health Care information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may also request a copy of the Notice at the front desk.

REQUESTING THE RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health information. If we agree to your request, the restriction will be binding with this office. Use or Disclosure of Protected Health Information in violation of the agreed upon restrictions will be a violation of federal privacy standards

REVOCATION OF CONSENT:

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has occurred prior to the date on which you revocation of consent is received will not be affected.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICE

This office reserves the right to modify the privacy practices outlined in this notice.

SIGNATURE:

I have reviewed this consent form and give my permission to this office to use and disclose my Health via this electronic signature.

Telemedicine Consent Form

1. By using the Accuhealth and Accucare of Texas telemedicine portal, I agree to receive telemedicine services. Telemedicine involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my Accuhealth and Accucare of Texas provider and I will be able to see and speak with each other from remote locations.
2. I understand and agree that:

I will not be in the same location or room as my medical provider.

My Accuhealth and Accucare of Texas provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.

Potential benefits of telemedicine (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my Accuhealth and Accucare of Texas provider's office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location.

Potential risks of telemedicine include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold Accuhealth and Accucare of Texas responsible for lost information due to technological failures.

I further understand that my Accuhealth and Accucare of Texas Provider's advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my Accuhealth and Accucare of Texas provider relies on information provided by me before and during our telemedicine encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.

I may discuss these risks and benefits with my Accuhealth and Accucare of Texas provider and will be given an opportunity to ask questions about telemedicine services. I have the right to withdraw this consent to telemedicine services or end the telemedicine session at any time without affecting my right to future treatment by Accuhealth and Accucare of Texas .

I understand that the level of care provided by my Accuhealth and Accucare of Texas provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be referred to the nearest Accuhealth and Accucare

of Texas clinic, hospital emergency department or other appropriate health care provider.

In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room. Please talk to one of our office staff if you have any complaints or issues with telemedicine.

CONSENT TO EXAMINATION AND X-RAY

I, the undersigned (electronically), a patient in this office hereby authorize Accuhealth and Accucare of Texas (or whomever they may designate as their associates or assistants) to perform the necessary examination and take the necessary x-rays and such additional examination or procedures as are considered necessary on the basis of clinical findings during the course of said examination and x-rays.

Section #2 POLICY ON X-RAY FILMS

All x-ray films taken or used in this office are the exclusive property of Accuhealth and Accucare of Texas . The films are a part of the permanent medical records file. We will make and or prepare a summary report to send to another doctor at a minimal charge, but the original films must remain in our files. Fees for x-rays are for the time and expenses involved in taking, developing, reading and interpreting the films by this office. If the provider for any reason finds it necessary to send the radiographs to a specialist for his opinion, a minimal charge may be added to the patient's account.

Section #3 CONSENT TO TREATMENT

I, the undersigned, hereby authorize Accuhealth and Accucare of Texas (and whomever he may designate as his acetates) to administer such treatment as is necessary, and to perform other procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

Section #4

I hereby certify that I have read and fully understand the above policy regarding examination, x-rays and treatment as well as possible complications or alternative modes of treatment, as explained. I also certify that no guarantee or assurance has been made as to the results that may be obtained as a result of treatment. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney in this case.

PATIENT'S BILL OF RIGHTS

I understand that Accuhealth and Accucare of Texas Physicians believes in the following Patient's Bill of
Rights .

Patient's Bill of Rights
You have the right to:
Have your pain prevented or controlled adequately
Have your pain and medication history taken Have your pain questions answered freely
Develop a pain plan with your physician
Know what medication, treatment or anesthesia will be given'
Know the risks, benefits and side effects of your treatment
Know what alternative pain treatments may be available
-sign a: statement of informed consent before any treatment
Be believed when you says you have pain
Have your pain assessed on an individual basis
Have your pain assessed using the 0= no pain, 10= worst pain, pain scale
Receive compassionate and sympathetic care
Receive pain medication on a timely basis
Refuse treatment without prejudice from your physician
Seek a second opinion or request a pain specialist
Be given you medical records on request
Include your family in decision making

PATIENT AUTHORIZATION AND ASSIGNMENT Authorization for direct payment

This authorization and assignment is irrevocable and applies only to the payment of medical expenses incurred at this office. I hereby authorize and direct any and all insurance companies or third party pay or accepting liability for payment of my injury claim, or are
contracted otherwise to furnish me medical payments benefits, to make and send payment directly to Accuhealth and Accucare of Texas at 620 James
Dr Richardson TX, 75080 for medical expenses incurred at this office. If payment is not made until time of settlement, I instruct the third party to issue a separate draft to be payable to the physician/clinic for the medical bills. In the event that the insurance company is unable to furnish separate payment for medical expenses, then I direct the insurance company making settlement of my claims to include Accuhealth and Accucare of Texas on any settlement or payment checks, and deliver check(s) to: 620 James Dr Richardson, TX 75080.

This agreement supercedes any agreement with my insurance company regarding payment and disbursement of funds for payment or settlement of my claim.

Assignment of benefits
For payment of any medical bills incurred at this office, I assign my insurance benefits to be paid directly to Accuhealth and Accucare of Texas at:
620 James Dr. Richardson, TX 75080 or
5601 Bridge Street Ste. 450 Fort Worth, TX 76112 or
1725 Main Street Ste # 2 Houston, TX 77002
.
I instruct any monies due from my personal injury protection to be paid directly to my physician.
Furthermore, claims shall be paid in accordance with Article 5.06-3, in a timely manner, not to exceed 30 days upon receipt of each claim.

I instruct my attorney to pay on full any outstanding monies due my physician at the time of settlement with any liability claim that may result from this case. My attorney shall not withhold any portion of the amount due to my doctor under this agreement to offset attorney's fees which my attorney now or hereafter may claim to be owed by me. I instruct my attorney to pay my doctor immediately upon settlement, by way of issuance of a separate draft made payable to the physician/clinic.

Assignment of Cause of Action
I hereby transfer the cause of action that exists in my favor against any insurance company that is contractually obligated to make payment for my claim. I authorize you, the doctor, to prosecute said section, or settle my medical bills as you see fit. It is understood that you will refrain from collection efforts directly from me, the patient, given that I have granted by this assignment all reasonable attempts to collect from the insurance company.

Authorization to endorse checks for medical expenses
For payment of medical bills incurred at this office only, I authorize this office to endorse any checks or settlement checks for payment of my bill. I understand that any overpayments of my medical bills incurred at this office will be refunded to me, the patient.

Authorization to release medical records
I authorize the release of any medical records necessary for my medical treatment, and to the insurance company for payment of my bills.

A photocopy of this form shall be as valid as the original.

Signature: _____