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[www.colemedical.health](http://www.colemedical.health)

## **Treatment & Benefits Consent**

*This form is called a Consent for Services (the "Consent") and Consent for assignment of benefits. Cole Medical asks that you read and sign this Consent before you begin as a patient of our practice. Please review the information. If you have any questions, contact us at [colemedical@icloud.com](mailto:colemedical@icloud.com) or 945-426-8057.*

### **HOUSE CALL SERVICES:**

- *This document gives us consent to come to your place of residence and to evaluate and treat your medical health needs.*
- *You have the right to refuse medical services and we will honor refusals when they are communicated.*
- *No guarantees have been made as to the outcome of these services by Cole Medical or any of its staff.*

### **TELEHEALTH SERVICES:**

- *To use telehealth, you need an internet connection and a device with a camera for video*
- *There are some risks and benefits to using telehealth:*

#### **• Risks:**

*- Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.*

*- Technology. At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions.*

*- Crisis Management. It may be difficult for your Provider to provide immediate support during an emergency or crisis. Your provider may direct you to call 9-1-1 or may do so on your behalf when deemed necessary.*

#### **• Recommendations:**

*- Make sure that other people cannot hear your conversation or see your screen during sessions.*

*- Do not use video or audio to record your session unless you ask your Provider for their permission in advance.*

### **BENEFIT RELEASE AUTHORIZATION:**

*• I authorize Cole Medical to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to be paid directly to Cole Medical. I authorize the release of all clinical information to any referrals I request.*

**Signature:** \_\_\_\_\_

**Printed name:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_