General Patient Consent

Consent for Evaluation and Treatment

To the Patient: Welcome to the Ko-Kwel Wellness Center. At this point in your care, no specific treatment plan has been recommended. This consent form is an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure(s) to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved.

Initials

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By initialing here, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. (3) you understand that you may be asked to sign a separate informed consent form for certain vaccines, lab tests, treatment(s) or procedures that require such. (4) you understand the consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Consent to Bill Insurance and Collect Payment

Initials

I have received a copy of the Ko-Kwel Wellness Centers Payment Policy, attached to this form. I hereby authorize the Ko-Kwel Wellness Center (KWC) to furnish information to insurance carriers concerning my conditions and treatments, and I hereby assign to the healthcare provider(s) all payments for services rendered to my dependents or myself. I authorize KWC to collect payments from third party payors such as Medicare/Medicaid and insurance companies. I have read and have had the opportunity to have my questions explained to me regarding my rights and responsibilities and payment policy under this agreement. My signature indicates that I consent to receiving services from the Wellness Center Staff at this time.

I acknowledge my responsibility to pay for care according to the fees established.

In the event that the patient is a minor, I am the parent and/ or guardian of said patient and I agree that I am responsible for all services provided to the patient herein

---

HIPAA Acknowledgement of Privacy Practices

Initials

I have received a copy of Ko-Kwel Wellness Center's "Notice of Privacy Practices." This Notice details the various rights granted to me, the patient, under the Health Insurance Portability and Accountability Act.

Patient Rights & Responsibilities

Initials

I have received a copy of Ko-Kwel Wellness Center's "Patient Rights and Responsibilities." This Notice details my rights as a patient and expectations of me throughout the course of my care at Ko-Kwel Wellness Centers.

Consent for Alternate person to bring Minor Child to Appointment

Initials

I understand that I, Parent/ guardian, must bring my child to the first appointment with a Ko-Kwel Wellness Center provider, in order to give a complete medical history. Following the first visit, I give permission for the following individual(s) to bring my child to Ko-Kwel Wellness Centers for treatment. I understand that by giving permission for this individual(s) to bring my child to their appointment the individual(s) is fully authorized to consent to treatment prescribed by the Ko-Kwel Wellness Center provider.

Alternate individuals that may bring child to Ko-Kwel Wellness Centers for treatment:

Name	Relationship
_____	_____
_____	_____
_____	_____

Attestation

By signing below, I attest I have received, reviewed, and understand the information above, and may revoke, in writing, my consent and discontinue my care at Ko-Kwel Wellness Center at any time.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature *(or Parent/Patient Representative)* Today's Date

_____
Name of Parent/Patient Representative