ASSIGNMENT AND RELEASE

By signing this form, I consent to and authorize CHAS Health to treat me. If this patient is a minor or unable to sign for themselves, I, as a legal guardian or power of attorney, consent to treatment of this patient.

I understand and agree that:

1. I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance.
2. I am financially responsible for all fees generated for services, supplies, and equipment provided by an outside provider (e.g. lab work) and that the outside provider may bill me directly for those fees.
3. Benefits of my insurance are assigned to CHAS Health.
4. These terms are non-negotiable. Attempts to modify these terms are void and my acceptance of healthcare services constitutes my full agreement with these terms.
5. I may receive healthcare through telephone or video connection, referred to as Telehealth. While telehealth has several benefits including increased access to healthcare, there are risks. I have the right to refuse treatment through telehealth at any time. Risks related to malfunctioning equipment or poor phone or internet connection may disrupt or delay care. In-person visits may be required. In very rare instances, security protocols could fail causing a breach of privacy or personal medical information. Please refer to the CHAS Notice of Privacy Practices for more information about how we secure private data
6. **I authorize CHAS Health to communicate with me using unsecure SMS text messaging, regarding my health care that may include protected health information.** I understand that exchanging email, text, or other written communications with my care team can result in disclosure of protected health information to unauthorized persons and that CHAS cannot control who views such information when sent unsecured. If I initiate or respond to communications using unencrypted pathways, I assume the risk that my information may be seen by a third party.
   I understand that I may opt-out of texting by replying 411stop at any time.
   I understand that I am not required to consent to receive text messages to receive services and that I may elect to sign a different form that excludes this text message consent.
   I understand that I am responsible for any costs associated with me receiving text messages, including data fees from my wireless carrier.
7. I authorize CHAS Health to contact me by telephone to remind me of appointments or to discuss my protected health information.
8. If I fail to keep my appointments or provide late notice of cancellation (within 4 hours of scheduled appointment) three in a three-month period, I may be restricted to same day only scheduling or walk-in status.

Electronic signatures. By signing below I agree that this document is deemed signed when a party’s signature is delivered electronically. The signor is executing this document

electronically and intends to be bound by the terms, statements and consents contained in this document and agrees that the electronic signature shall be deemed original signatures having the same legal effect as original signatures to the fullest extent permitted by applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, and any similar state law based on the Uniform Electronic Transactions Act, and the parties hereby waive any objection to the contrary. The signor acknowledges that this term is hereby incorporated into the Agreement/Document.

__________________________________ ______________________________

Signature of Patient or Authorized Representative | Date

02-24-21

ASSIGNMENT AND RELEASE

By signing this form, I consent to and authorize CHAS Health to treat me. If this patient is a minor or unable to sign for themselves, I, as a legal guardian or power of attorney, consent to treatment of this patient.

I understand and agree that:

1. I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance.
2. I am financially responsible for all fees generated for services provided by an outside specialist (e.g. lab work) and that the outside specialist may bill me directly for those fees.
3. Benefits of insurance are assigned to CHAS Health.
4. These terms are non-negotiable. Attempts to modify these terms are void and my acceptance of healthcare services constitutes my full agreement with these terms.
5. You may receive healthcare through telephone or video connection, referred to as Telehealth. While telehealth has several benefits including increased access to healthcare, there are risks. You have the right to refuse treatment through telehealth at any time. Risks related to malfunctioning equipment or poor phone or internet connection may disrupt or delay care. In-person visits may be required. In very rare instances, security protocols could fail causing a breach of privacy or personal medical information. Please refer to the CHAS Notice of Privacy Practices for more information about how we secure private data
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______________________________ ____________________

Signature of Patient or Authorized Representative Date

About Our Notice of Privacy Practices

The CHAS Health is committed to protecting your personal health information. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information
- how we may use and disclose the health information that we keep about you
- your rights relating to your personal health information
- how to file a complaint if you believe your privacy rights have been violated
- the conditions that apply to uses and disclosures not described in this Notice
- the person to contact for further information about our privacy practices

We are required by law to give you a copy of this notice and to obtain your written acknowledgment that you have received a copy of this notice.

BY MY SIGNATURE BELOW,
I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

Signature of Patient or Authorized Representative ____________________

Date ____________________

Printed Name if Signed on Behalf of Patient ____________________

Relationship (parent, legal guardian, personal rep, etc) ____________________

This form will be retained in your Medical Record.
CHAS Health Patient Acknowledgment of Receipt of Notice or Privacy Practices