DR. ANGELA OVERSTREET WRIGHT

2607 Commons Blvd. Augusta, GA 30909
Office Phone 706-750-8601 Fax 762-994-1086

I _____ DOB _____ acknowledge the below statements by initialing each item.

_____ I hereby give my consent to Health Done Wright, Inc for medical treatment. I consent to the physician, and/or Nurse Practitioner, or Physician Assistant, and other health care providers or the designee as deemed necessary, to perform reasonable and necessary medical examination and testing to include photographing or digital recording of images for medical purposes. I understand that information obtained through questionnaires, physical examination, and photographing/digital image recordings may be part of the evaluation, examination, and follow-up process, and this information will only be utilized to help the provider determine the appropriate treatment for the condition(s) which has brought me to seek care at this practice. I understand that if additional testing, invasive, or intervention procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s) being performed. This consent for treatment will be valid for as long as I seek healthcare services at Health Done Wright Inc.

_____ I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment.
- a means of communication among the health professionals who may contribute to my healthcare.
- a source of information for applying my diagnosis and surgical information to my bill.
- a means by which a third-party payer can verify that services billed were actually provided.
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

_____ I hereby give my consent for the doctor and staff of HEALTH DONE WRIGHT, INC. to disclose/share my protected health information (PHI) with the following person(s). The

person(s), I listed below have an active role in helping me manage my health issues and/or serve as a contact in the case of emergency.
I may revoke my consent in writing except to the extent that the practice has already made disclosure upon my prior consent.

1. Name_____ Relationship_____

   Contact number _____ Emergency Contact __ Yes __ No

   Permission for portal access (email)_____

2. Name_____ Relationship_____

   Contact number _____ Emergency Contact __ Yes __ No

   Permission for portal access (email)_____

_____ I acknowledge that Health Done right, is not a pain management office. There is no guarantee that pain medicines or other controlled substances issued by another provider will be continued by Dr. Wright at the time of your visit. Dr. Wright relies on information obtained during the physical examination and from diagnostic test and image, to determine the appropriate treatment for your issue. Dr. Wright does not initiate Adult ADD medications.

_____ I **Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))**

- I have the right to review this Practice's Notice of Information practices prior to signing this consent.
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested.
- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this Practice has already acted in reliance thereon.

_____ I give permission to my healthcare provider to collect and share my pharmacy and health insurer information about my prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date signed _____