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 _____

$50 No-Show/Late Cancellation Fees

To provide you and all patients of Dr. Angela O. Wright the best possible care, a minimum of 24-hours' notice is required to cancel or reschedule your appointments.

I, _____ understand the importance of notifying Health Done Wright, Inc., at least 24-hours prior to my scheduled appointment that I am not able to keep my appointment. If I do not give a 24-hour notice, I will be charged a $50 no-show fee for missing the appointment. I understand this fee is not covered by my insurance and it is my responsibility to pay this fee.

Signature _____

Payment of Fees, Copayments, and Deductibles

I _____understand that my insurance may require me to pay a copayment as well as I may have a specific deductible that I must meet before the insurance will pay anything towards my medical bills. I understand this may subject me to paying for the cost of the medical treatment(s) I receive at Health Done Wright, Inc. Therefore, I desire to leave a credit/debit card on file to pay these fees. I understand that I may revoke this agreement at any time by providing a request in writing to the office. I also understand that when medical services with Health Done Wright, Inc end, this agreement also ends.

I _____ am requesting that this card be used for payment of services (co-pays & fees)

Name on card_____

Card# _____-_____-_____-_____ Type ☐ Visa ☐Master Card ☐Discover ☐Amex

Expires _____/_____ CCV Security Code on back _____ Zip Code _____

Email address to send the receipt: _____

Signature _____

Health Done Wright, Inc

Release of Medical Information Authorization Form

I, _____ _____
(Print Name) (Date of Birth)

Consent to the release of my medical records to

Health Done Wright, Inc. office of Dr. Angela Overstreet Wright
2607 commons Blvd, Augusta Ga 30909
Office Phone [706]-750-8601
Records can be mailed address above or
Faxed to [762]-994-1086

I understand the information may include reference to psychiatric/psychological care, drug and alcohol abuse information, and/or result of test for all infectious diseases including HIV/AIDS. I understand that I have a right to revoke this authorization at any time. I understand that if I wish to revoke this authorization I must do so in writing and present my written cancellation/revocation to Dr. Angela Overstreet Wright or the office manager. I understand the cancellation/revocation is only applicable for the date submitted and does not apply to information that has already been released in response to this authorization. Unless otherwise cancelled or revoked, this authorization will expire one year from the date of signature below

_____ _____
Signature Date

This section to be completed by the office staff

The patient above has consent for our office to retrieve a copy of their medical records from your office.

Name of healthcare provider or facility _____

Phone _____ Fax _____

Please share the following information:

Address _____
____Office notes including H&P _____
____Lab Results for _____
____X-Ray images of _____
____Procedure Report for _____
____Hospital Notes from _____
____Emergency Notes from _____
____Immunization Records _____
____Medication List _____
____Psychotherapy Notes _____
____ Other _____