CONSENT TO TREATMENT

I (the patient/guardian/legal representative to the patient acting on the patient's behalf) give permission for medical treatment, including radiological and laboratory procedures, to be performed by the physicians, nurse practitioners, physician's assistants and staff of Covenant Medical Group/FamilyFirst Healthcare.

PHARMACY/MEDICATION HISTORY: I authorize Covenant Medical Group/FamilyFirst Healthcare to obtain all of my medication history, in any format, to provide my medical care.

This consent is valid from this date forward.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed Covenant Medical Group/FamilyFirst Healthcare's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if requested.

ADVANCED DIRECTIVE LIVING WILL

Do you have an advanced directive/living will? __ Yes __ No

If you answered No, would you like more information on Advanced Directives? ___ Yes ___ No

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE PUT A ✓ IN EACH SECTION):

- ☐ Home Telephone _____
  - ☐ Leave a message with detailed information
  - ☐ Leave a message with call back number only
  - ☐ Please **do not** leave a message
- ☐ Work Telephone _____
  - ☐ Leave a message with detailed information
  - ☐ Leave a message with call back number only
  - ☐ Please **do not** leave a message
- ☐ Mobile Telephone _____
  - ☐ Leave a message with detailed information
  - ☐ Leave a message with call back number only
  - ☐ Please **do not** leave a message
- ☐ Fax Number: _____
  - ☐ Please **do not** fax any information to me

- ☐ Written Communication
  - ☐ Mail to my home address
  - ☐ Mail to my work/office address
  - ☐ Please **do not** mail
- ☐ The following people may have access to my medical information:
  - ☐ Spouse/Significant Other: _____
  - ☐ Child: _____
  - ☐ Child: _____
  - ☐ Child: _____
  - ☐ Other:_____
  - ☐ Nobody should have access

TELEPHONE CONSUMER PROTECTION ACT

By providing us with a telephone number for a cellular or other wireless device, you agree that in order for us or our service providers to service your account(s) (including contacting you about obtaining potential financial assistance for your account(s)) or to collect any amounts you may owe, we, our agents, representatives, or other service providers may contact you at the above listed telephone number(s) which could result in charges to you. You expressly consent that methods of contact may include using pre-recorded and artificial voice messages and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with this account and is not a condition of purchasing property, goods, or services. You are not required to sign this consent as a condition of treatment.

Initials Here to Decline: ☐

_____ _____ _____

Patient/Patient Representative Signature | Relationship to Patient | Date/Time

_____ _____ _____

Witness Signature | Reason Patient is Unable to Sign | Date/Time

ADDITIONAL CONSENT REGARDING SERVICES PERFORMED IN TEXAS

I understand that the physicians and other clinical staff employed by Covenant Medical Group ("CMG") and FamilyFirst Healthcare ("FFHC") are licensed by the state of Texas, and that the medical services provided to me by CMG/FFHC and its affiliated health care providers will be rendered in Texas. As such, I agree that the relationship between myself and CMG/FFHC (inclusive of its affiliated physicians and other health care providers) for care provided in Texas will be governed by Texas laws without regard for conflicts of laws principles. I also agree that any lawsuit or other dispute arising from or related to medical care I receive from CMG/FFHC and/or its affiliated physicians or other health care providers will be brought only in an appropriate court located in Lubbock County, Texas.

The above authorized information will apply to all Covenant Medical Group/FamilyFirst Healthcare providers and remains in effect until additional notice or changes are made by the patient.

Relationship to Patient: ☐ Self ☐ Child ☐ Dependent ☐ Other: _____

_____	_____	_____
Printed Name Birthdate	Signature	Date

_____	_____	_____
Printed Name of Witness	Signature of Witness	Date