Comprehensive Client Consent Form

Patient Name (Print): _____Date:_____

1. **Authorization for Medical Care**

I authorize Help-Us Help-U and its healthcare providers to:

- Assess, diagnose, and treat my medical conditions.
- Provide primary care, preventive care, screenings, and lab tests.
- Offer mental health and substance use disorder services.
- Manage my medications.
- Provide other necessary healthcare services.

2. **Specific Disease Consents**

I consent to testing, treatment, and related services for HIV, STIs, and HCV. I understand:

- The nature, purpose, benefits, and risks of these services.
- The confidentiality of my information.
- My right to decline any testing or treatment.

3. **PrEP Consent**

I am interested in taking PrEP (pre-exposure prophylaxis) to reduce my risk of acquiring HIV. I understand:

- PrEP is a daily medication that can significantly reduce the risk of HIV infection.
- I will need regular HIV testing and follow-up visits with my healthcare provider.
- There may be side effects associated with PrEP.
- PrEP is not 100% effective, and I still need to practice safer sex.

4. **Authorization for Release of Information**

I authorize the release of my health information, including substance use disorder information, to:

- Other healthcare providers are involved in my care.
- The Florida Department of Health for disease reporting.
- Other individuals or organizations with my separate, specific authorization.
- Health Information Exchanges (HIEs) for treatment, payment, and healthcare operations.

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5. **Telehealth Consent**

I consent to telehealth services and understand:

- The potential limitations compared to in-person visits.
- The potential risks and benefits.
- The importance of secure communication.

6. **Behavioral Health Consent**

I consent to receiving behavioral health services, including assessment, diagnosis, treatment, and counseling, from qualified mental health professionals at Help-Us Help-U. I understand that:

- My behavioral health information will be kept confidential, except as required or permitted by law.
- I have the right to participate in treatment decisions and to refuse any treatment or medication.
- I may be asked to sign additional consent forms for specific behavioral health services or treatments.

7. **Photographs and Videos**

I consent to Help-Us Help-U taking photographs or videos of me for the following purposes: [Specify purposes, e.g., educational, promotional, or documentation]. I understand that:

- My identity will be protected to the extent possible.
- I can withdraw this consent at any time by notifying Help-Us Help-U in writing.

8. **Financial Assistance and Enrollment**

I authorize Help-Us Help-U, its pharmacy, or collaborating partners to:

- Enroll me in any available pharmaceutical patient assistance programs, copay assistance programs, or foundation programs related to the services provided.
- Request financial assistance on my behalf from organizations such as Gilead, ViiV Healthcare, or any other foundation programs, especially if I am uninsured or have limited insurance coverage, to help cover the cost of medications or healthcare visits.

I understand that:

- Help-Us Help-U or its partners will assist me in applying for these programs.
- My health information may be shared with these programs as necessary for enrollment and eligibility determination.

- I am responsible for any costs not covered by these programs or my insurance.

9. **Financial Policies**

I understand that I am responsible for any charges not covered by my insurance or assistance programs. I agree to pay any outstanding balances in accordance with Help-Us Help-U's billing policies. I have been informed of the following:

- Billing practices
- Insurance acceptance
- Self-pay options

10. **Patient Rights**

I understand that I have the following rights:

- The right to access my medical records.
- The right to participate in treatment decisions.
- The right to refuse treatment.
- The right to file a complaint if I am dissatisfied with my care.

11. **Additional Consents & Acknowledgements**

- I received the Notice of Privacy Practices.
- I consent to the collection and use of my social security number for billing and identification.
- I authorize Medicare (if applicable) to pay directly and release information for billing.
- I consent to using a patient portal (if available).
- I consent to receive appointment reminders and communications via email or text.
- I am aware of the grievance procedure.

12. **Marketing Communication Authorization**

I understand that authorizing marketing communication from this practice means I may:

- Receive treatment communications concerning treatment alternatives or other health-related products or services.
- Be contacted for appointment reminders or information about treatment alternatives or other health-related benefits and services that may interest me.
- I have the right to "opt out" of receiving such communications at any time.

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Marketing Authorization Options:

- ☐ I wish to receive Marketing Communications from this Practice Only
- ☐ I wish to receive Marketing Communications from this Practice, and this Practice's Business Associates.
- ☐ I do NOT wish to receive any Marketing Communications

Summary of Marketing Communication Authorization

This section explains that by consenting, you may receive communications from the practice about treatment options, health-related products/services, and appointment reminders. You can choose to receive these communications only from the practice or also from their business associates. You also have the right to opt out of receiving these communications at any time.

Additional Information Regarding Marketing Communications

- Communications encouraging you to use our services are considered marketing.
- We must obtain your written authorization before using or selling your Protected Health Information (PHI) for personal gain or commercial advantage.
- Authorization is required for all treatment and healthcare operations communications where we receive financial remuneration from a third party for making the communication.
- We are NOT receiving financial remuneration from a third party for marketing purposes.
- "Financial remuneration" does not include non-financial benefits (like in-kind benefits) received in exchange for making a communication.
- The financial remuneration must be specifically for making the communication and must encourage individuals to purchase or use the third party's product or service.

Help-Us Help-U Privacy Officer: Lisa Conder

Emergency Contact Information

Name: _____Relationship:_____

Phone Number: _____

For Minors (if applicable)

I, _____ (parent/guardian), consent on beh_____ (minor). I have been informed of and consent to the items listed above on behalf of the minor.

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Expiration of Consent: This consent is valid until revoked in writing.

Right to Revoke: I can revoke this consent at any time in writing, except for actions already taken based on my prior consent.

Patient Signature: _____ **Date:** _____

Practice Signature: _____ **Date:** _____

Witness Signature (if applicable): _____**Date:** _____