Patient Name: _____
Patient Address: _____
Date of Birth: _____

Denova Patient Consents

(Must be signed every year)

CONSENT FOR EVALUATION AND/OR TREATMENT **Accept ☐ Do Not Accept ☐**

Welcome to Denova Collaborative Health, LLC (Denova). We want to help you feel better. We may offer you different services, like seeing a primary care provider, talking with a therapist, or getting help from a psychiatry provider.

You are choosing to get help for a physical, mental, or behavioral health issue on your own. By doing this, you agree to let the healthcare providers examine you, give you treatments, coordinate care or complete tests that they think are best for you. These providers can include doctors, psychiatrists, nurse practitioners, physician assistants, psychologists, counselors, social workers, and family therapists. It's important to know that there are both good and bad things that can happen during treatment. Healthcare is not an exact science, and you acknowledge that no guarantees have been made as to the result of such examinations, treatments, and/or diagnostic procedures.

You understand that if the patient is a minor under the age of 18, you are consenting to treatment on the minor's behalf. If you share custody of the young person getting treatment, signing this form means you're saying that everyone who has custody knows and agrees to the treatment. You've had a chance to ask questions, and all of them have been answered in a way that makes you feel comfortable. You can change your mind and withdraw your Consent to Treatment at any time.

By signing this form, you agree that you are here because you want to be and that you understand the kind of help we may offer you.

NOTICE OF PRIVACY PRACTICES **Accept ☐ Do Not Accept ☐**

At Denova, we know that it is important to keep your information safe. We will not share your information with anyone without asking you first. We will use your information to help you get better. We will use your information to get paid for the services we provide. We will use your information to follow the rules that help us run our medical practice. Your reproductive healthcare information, including services related to contraception, pregnancy, and related treatments, is protected under federal privacy laws. We will not disclose this information without your explicit written consent, except as required by law or in situations necessary to prevent harm.

You can find our most current Notice of Privacy Practices on our website: https://www.denova.com/wp-content/uploads/2023/10/Notice-of-Privacy-Practices-NPP-Denova-ENGLISH-07.2023.pdf . You may also request a printed copy to review.

By signing this document, you agree that you have read and understand Denova's privacy practices.

TELEHEALTH INFORMED CONSENT **Accept ☐ Do Not Accept ☐**

To use telehealth in Arizona, you must be in Arizona at the time of your appointment. You also need to be in a quiet place where you can talk and listen without being interrupted.

Healthcare providers for physical and mental health can offer telehealth services. If you receive reproductive healthcare services via telehealth, your rights to privacy and confidentiality remain the same as in-person care. Our platform complies with federal and state laws to protect your health information, and we will not share details of your

reproductive care without your explicit consent, except where required by law. Denova will do what is needed to keep your health information private.

Using telehealth has some risks. For example, the equipment might not work right, or the person helping you might have trouble seeing or hearing you. There's also a chance that your private medical information might not be secure. In some cases, the person helping you might not have access to your whole medical history. To avoid these risks, you can decide to get services from us in person instead of using telehealth services.

By signing this document, you agree that you have read and understand the possible risks of using telehealth services.

PROFESSIONAL DISCLOSURE STATEMENT **Accept ☐ Do Not Accept ☐**

Some of our providers are still in training and working to get their licenses. They see our patients under the supervision of a fully licensed provider in accordance with applicable law. This applies to:

- Master's Level Interns
- Licensed Associate Counselors (LAC)
- Master's Level Social Workers (LMSW)
- Associate Marriage and Family Therapists (LAMFT)

Our providers in training may share information about your treatment with their supervisors.

By signing below, you agree to treatment by providers in training and disclosures regarding your treatment to their supervising providers.

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY **Accept ☐ Do Not Accept ☐**

A medication history is a list of all the medicines you take. It helps your healthcare provider make sure you are getting the right treatment and not taking any medicines that might be dangerous together.

It is important to tell your healthcare provider about all the medicines you take. Even the ones you can buy without a prescription, like vitamins or herbal supplements. These might not be in your medication history.

By signing this form, you agree to let your healthcare provider see your medication history and that they can get it from other healthcare providers, your insurance company, and pharmacies.

CONSENT TO COORDINATE CARE WITH YOUR PRIMARY CARE PROVIDER (PCP) **Accept ☐ Do Not Accept ☐**

By providing your Primary Care Provider (PCP) information, you consent to the release of your healthcare information to your provider to coordinate care.

FINANCIAL POLICY **Accept ☐ Do Not Accept ☐**

Denova checks with your insurance company to see what your benefits are. But the quote they give you is not a promise that your insurance company will pay. You have to pay for the services you receive unless you make other arrangements with them beforehand. You also have to pay your deductible, copay, and/or coinsurance at the beginning of each visit. If you owe more money after your visit, you will receive a bill. If you have a credit, you will get a refund. Even if a healthcare provider refers you to Denova, your insurance company may not cover their services. You are responsible for paying all the charges.

Primary Care wellness exams are preventive-only visits. If additional health concerns are discussed and evaluated during the visit, a separate office visit charge with copay may be applicable.

You can pay with a cashier's check, money order, debit card, or credit card. Debit card and Credit card information may be saved in your file for future use on your account. We will not charge your card on file without your consent. You cannot pay with cash or a personal check. Before you are treated, Denova recommends that you check with your insurance company to see what they will pay for. You can refuse any procedure or treatment if you want to.

From January 1, 2022, a law called the No Surprises Act (NSA) protects people who don't have health insurance or pay for their medical bills themselves. If you choose not to use your health insurance or don't plan to pay with it for your treatment at Denova, we can give you an estimate of the amount we might charge you before you receive the treatment.

By signing below, you agree that you know and understand the way Denova handles payments.

NO SHOW POLICY **Accept ☐ Do Not Accept ☐**

When you get care from Denova, you agree to try your best to follow your treatment plan. If you can't make it to an appointment, you need to call Denova at least 24 hours before your appointment. When you call, you can tell us that you want to cancel your appointment. Denova may charge you a fee if you cancel less than 24 hours before your appointment. If you cancel three or more times in a row without telling Denova ahead of time, Denova may decide not to treat you anymore.

By signing your below, you agree that you understand the policy about missing appointments without telling Denova first.

PATIENT CODE OF CONDUCT **Accept ☐ Do Not Accept ☐**

Denova will treat you with kindness, respect, and dignity. They will help you feel safe and supported. It is important that you follow your treatment plan to get the best results. If you do not follow the rules, Denova may stop treating you and suggest other places for you to get care.

By signing this document, you agree to the following rules:

- You will follow your treatment plan.
- You will not hurt yourself or others.
- You will not use bad words or shout at yourself or others.
- You will not threaten to hurt anyone.
- You will not come to your appointments after using alcohol or drugs.

PATIENT RIGHTS **Accept ☐ Do Not Accept ☐**

When you get care from Denova, you have a responsibility to be involved in the decisions about your care. Denova wants you to be a part of your treatment and work together to get better. You have the right to access comprehensive reproductive healthcare services, including but not limited to contraception, pregnancy-related care, and counseling. Our facility follows all applicable federal and state laws, ensuring your right to receive medically necessary reproductive healthcare without discrimination or restriction.

Here are some of the things you can do to be involved in your care:

- Ask questions about your condition and treatment.
- Talk to your healthcare provider about your goals for your care.

- Make sure you understand your treatment plan.
- Give your healthcare provider feedback about your care.
- Be an active participant in your care.

You can find our Patient Rights and Responsibilities on our website: Patient-Rights-Responsibilities.pdf You may also request a printed copy to review.

By signing this document, you agree that you have read and understand your rights as a patient.

EMERGENCY PROCEDURES **Accept ☐ Do Not Accept ☐**

If you have an emergency during your visit to Denova, you should follow these steps:

- If it is a medical emergency, you can call 911 or your provider/clinician will call 911 for you and stay with you until help arrives.
- If it is a behavioral health emergency, you or your provider/clinician can call the National Crisis Line at 988 or local crisis services, and your provider/clinician will stay with you until help arrives.
- If you need help outside of normal business hours, you can call our after-hours service team for non- urgent medical questions that may happen at night, on weekends, or holidays.

It is important not to send any details about a medical or behavioral health emergency through text messages or other channels that are not secure.

By initialing and signing, you show that you understand Denova's emergency procedures as they have been explained to you.

PUBLIC HEALTH REPORTING **Accept ☐ Do Not Accept ☐**

We can tell the government about your health to help with public health things, like when vaccines might cause problems or when there are contagious illnesses. Certain reproductive health conditions, such as sexually transmitted infections (STIs) or complications from pregnancy, may be reportable to public health agencies per federal and state law. However, we will limit disclosures to only the necessary information required by law and will notify you when such a report is made, unless the law prohibits notification.

By signing below, you agree to share your records with ASIIS. Signing is not necessary to receive vaccinations.

PHONE AND EMAIL CONTACT CONSENT AND AUTHORIZATION **Accept ☐ Do Not Accept ☐**

You consent to and authorize Denova or any of its automated systems to call or text you, and leave voicemails for you, about any services you get from Denova. The messages may be about bills, appointments or information about your health. These messages may not private because texts, voicemail and email can be intercepted while they are being sent, accidentally sent to the wrong person or seen by anyone who has access to your device.

Denova does not charge any fee to send voicemails or emails, but your phone company might. You do not have to agree to text, voicemail or email messages. If you do not to agree, it will not affect the care you receive. You can notify Denova if I choose to stop the messages. To stop text messages, you can text the word “STOP” to cancel at any time.

Patient Name: _____
Patient Address: _____
Date of Birth: _____

By signing this Patient Consent Form, you confirm that you have read and fully understand the information and voluntarily consent to its contents.

Patient Signature	**Date** (MM/DD/YYYY)
Patient Printed Name	**Check this box if patient is below the age of 18:** ☐

Parent or Legal Representative Signature	**Date** (MM/DD/YYYY)
Parent or Legal Representative Printed Name	
Relationship if Not Patient ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Foster Parent ☐ Health care POA ☐ Other_____	

Parent or Legal Representative Signature	**Date** (MM/DD/YYYY)
Parent or Legal Representative Printed Name	
Relationship if Not Patient ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Foster Parent ☐ Health care POA ☐ Other_____	

Patient Name: _____
Patient Address: _____
Date of Birth: _____

HEALTH INFORMATION EXCHANGE (HIE)
CONSENT TO RELEASE TREATMENT INFORMATION

Patient Name: _____ Date of Birth: _____

By signing this form, I permit all of my past, present and future healthcare providers where I have received medical or behavioral health treatment, including any treatment for substance use disorders, and Health Current, Arizona's health information exchange (HIE), to release information about my treatment to the organization to Denova Collaborative Health. I also permit Denova Collaborative Health to disclose all of the above categories of information regarding its treatment of me to the HIE.

I am receiving (or will receive) treatment from Denova Collaborative Health. The disclosure of this information is for treatment, payment, and healthcare operations purposes.

I authorize the disclosure of all my physical and behavioral health information and substance use disorder information (*e.g.*, drugs and alcohol treatment), including my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health, communicable disease-related information and HIV/AIDS- related information.

I understand that this information may be securely shared through the HIE. I understand that if I previously opted out of having my health information shared through the HIE this form will change that decision. That is because the HIE is the way the organization described above might get my information. I agree to have all of my health information shared through the HIE. I understand that I can change this decision at any time.

I understand that I may cancel this consent at any time, except where someone already relied on my consent to release the information. If I want to cancel my consent or if I have questions, I will contact Denova Collaborative Health. Unless I cancel this consent earlier, it will remain in effect until I stop treatment with Denova Collaborative Health or my death. I understand that my substance use disorder treatment information will continue to be protected by federal law when it is released to the organizations listed above.

_____ _____
Signature of Patient* Date

_____ _____
Signature of Parent/Guardian *(If Patient is a child under the age of 18)* * Date
*Both the child and parent/guardian must consent to disclosure of the child's **substance use disorder information**, unless the child is married, homeless, or emancipated.

_____ _____
Signature of Patient's Health Care Decision Maker Date
(If Patient has been declared incompetent by a court or is deceased)

Notice to Recipient of Substance Use Disorder Treatment Information: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The Federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.