Activate Healthcare Patient Consent

Please print clearly and legibly when completing this form.

Patient Information

Last Name:*	Legal First Name:*	M.I.:
Date of Birth (mm/dd/yyyy):*	Email Address:*	

☐ I DO NOT authorize Activate Healthcare to use this email address to send notices related to appointments, and notices directing me to the secure online health portal to view lab results or messages from my provider. (NOTE: Activate Healthcare's communications will NOT include sensitive information such as mental health information or sensitive testing).

☐ I DO NOT authorize Activate Healthcare to send me text messaging (SMS) notifications on up-to-date account alerts and information.

Do you have other insurance? ☐ Yes ☐ No	If Yes, what is the name of your insurance provider?
Do you have Medicare as your primary insurance?* ☐ Yes ☐ No	

Note: Dependents' contact and mailing information are assumed to be the same as those of primary. Please contact your Activate Health & Wellness Center if you need to modify.

Patient Acknowledgments

By signing below, I acknowledge that the Activate Healthcare Notice of Privacy Practices and Terms and Conditions were provided and/or made available to me. I have read and agree to Activate Healthcare Notice of Privacy Practices and Terms and Conditions. I am authorizing myself, my spouse or partner and all dependents for whom I am the legal parent, guardian or personal representative to use Activate Healthcare.

Signature of Patient or Legal Guardian

Signed Date

*Required information

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Activate Healthcare Patient Consent

ACTIVATE HEALTHCARE™

Welcome to Activate Healthcare! We are honored to be your healthcare partner and are committed to delivering quality care and service. Your Activate Healthcare provider is at the very center of your health care, ensuring that you're taking all the right steps toward healthier living.

By signing this Patient Consent, you hereby request, consent and authorize Activate Healthcare and its subsidiaries, affiliates and agents and their employed or contracted providers to access, diagnose, consult and treat you. As an Activate Healthcare patient, services described in Section 1 will be made available to you pursuant to the terms of this Membership Agreement.

1. Our Services

As a patient, you are eligible to receive primary care, preventive care, and urgent health care services as offered by your Activate Healthcare provider. Activate Healthcare has prepared a detailed services list summarizing the available health care services offered to patients. During the term of this agreement, the health care services provided by Activate Healthcare may be subject to change. Changes, if any, shall be reflected on the detailed services list.

At this time, Activate Healthcare is not credentialed with government health programs, such as Medicare, and we cannot provide care for patients who are covered by Medicare Part B as their primary insurance.

2. Fees and Payment

Most, but not all, of the services listed above in Section 1 are paid for by your employer. if you participate in a high-deductible health plan with a health savings account feature, you may be required to pay a fair market value fee for certain non-preventive and urgent services until your deductible has been satisfied. If you do not pay on a fee-for-service basis for these services, you may lose your ability to contribute to your health savings account.

3. Your Medical Information

Your privacy is very important to us and you control the use of your personal information. Activate Healthcare has put important safeguards in place to make sure your medical information is protected and safe to maintain its confidentiality. Having access to your medical information will help your Activate Healthcare providers give you the best care possible and ensure we have the most up-to-date information about your health. Therefore, as allowed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your organization-sponsored group health plan and its contractors and agents (Health Plan) may electronically share with us your health-related information (including your "protected health information" as defined by HIPAA). To learn more about our Notice of Privacy Practices, visit https://www.activate-healthcare.com/privacy-policy or contact your Activate Health & Wellness Center to obtain a copy.

Your medical information may be shared with a health information exchange (HIE) system in the state that you reside. HIE allows health care providers and patients to securely share and access medical information electronically. You have the option to opt-out and prevent your health information from being viewed from your state's HIE system. If you choose to opt-out, your providers may not have immediate access to all of the important information needed to make the best decision about your healthcare. You may request to opt back in at any time. To learn more about your opt-out and opt-in options, contact your Activate Health & Wellness Center.

A Healthcare Effectiveness Data and Information Set (HEDIS) is used to measure performance on care and service. Under the Health Insurance Portability and Accountability (HIPAA) Privacy Rule, a healthcare provider is permitted to release protected health information (PHI) to a health plan for HEDIS purposes without patient consent or authorization. HEDIS data is reported collectively and will not include specific individual patient identifiers.

Your organization may provide incentives for participating in a wellness program. If so, you hereby authorize Activate Healthcare to share information about your wellness program participation with your organization for the purposes of determining your eligibility for an incentive.

4. Digital Communication

Activate Healthcare offers virtual care services and the ability to send and receive emails to and from their care team via the online health portal. Virtual care uses technology to enable Activate Healthcare providers the ability to evaluate and treat patients as an alternative to an in-person office visit. Your provider will determine whether a virtual care visit is medically appropriate for your condition. During your appointment, details of your medical history, examinations and diagnoses will be discussed. Physical examination and video, audio and/or photos may be taken during the appointment. There are potential risks and technical failures when using virtual care including interruption and/or disconnection of audio/video. Virtual care is not intended to replace a relationship with your provider and patients have the option to withhold or withdraw this consent at any time. While Activate Healthcare takes many precautions to protect your information and the security of the emails we send and through virtual care appointments, there are still risks and we cannot guarantee all digital communications are secured and confidential. We recommend you do not send sensitive information through mobile text messages. Text messages can remain stored on portable mobile devices for an indefinite period of time and may be exposed to unauthorized third parties. You are responsible for protecting your email account password, mobile device or other means of access to your email and virtual care appointments. Activate Healthcare is not liable for improper disclosure of confidential information that is not caused by Activate Healthcare's misconduct. You are responsible for informing Activate Healthcare if you want to cease or limit communications with Activate Healthcare. You may do so at any time without reason or explanation. By signing this agreement, you acknowledge that you have read this section and understand the risks and benefits of using Activate Healthcare's digital communication methods.

5. Non-discrimination

Activate Healthcare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, physical gender, sexual orientation, or gender identity.

Activate Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, physical gender, sexual orientation, or gender identity.

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Permission to Discuss Health Information with Other Individuals

Please print clearly and legibly when completing this form.

Patient Information		
Last Name:*	Legal First Name:*	M.I.:
Date of Birth (mm/dd/yyyy):*		
Phone (mobile):	Phone (home):	
Phone (work):	Preferred phone (select one): ☐ Mobile ☐ Home ☐ Work	

☐ I currently do not wish to give Activate Healthcare, its subsidiaries and associated organizations ("Provider") permission to discuss my health information with any friends or relatives. I understand that if this request changes I am required to submit a new permission form.

☐ I hereby grant Activate Healthcare, its subsidiaries, and associated organizations permission to discuss my health information with the persons listed below as it relates to their involvement in the coordination of my care and payment for health care services I receive.

Name	Relationship (friend, relative, etc.)	Phone Number

Would you like Activate Healthcare employees to leave detailed health information on voicemail?

☐ Yes ☐ No If yes, what phone number can we call? ( ) ____________________

This form supersedes any and all previously completed forms. All previous forms are hereby revoked.

Signature of Patient or Legal Representative Date of Signature

If the patient is a minor or has a personal representative, I represent that I am the legal/parent/guardian/personal representative of the patient named above and I am not prohibited by Court Order from releasing access to the requested information.

Signature of Patient or Legal Representative Date of Signature

*Required information

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Authorization to Release Protected Health Information

Request a copy of your medical records or send your records to Activate Healthcare or another provider.
Please print clearly and legibly when completing this form.

Patient Information

Last Name:*	Legal First Name:*	M.I.:
Address:*		Apt#:

City:*	State:*	Zip:*	Date of Birth (mm/dd/yyyy):*	

Step 1: Tell us what you would like to do.

☐ Obtain a copy of my Activate Healthcare records (Skip steps 2 & 3)

☐ Send my Activate Healthcare records to another provider

☐ Obtain a copy of my health records from another provider and send to Activate Healthcare

Step 2: Provide contact information for the non-Activate Healthcare provider.

Name of Physician/Provider:

Address:*

City, State, Zip:*

Phone: Fax:

Step 3: Verify your Activate Healthcare provider information.

Activate Healthcare Clinic:

Address:*

City, State, Zip:*

Phone: Fax:

Purpose of Disclosure: (Please check one)

☐ Individual's request ☐ Legal ☐ Insurance ☐ Other: ______________________

Purpose of Disclosure: (Please check one)

☐ All records retained by provider

☐ The types of records indicated below between the following dates of service: from ______________ to ______________

☐ Progress notes ☐ Laboratory reports ☐ Immunization records ☐ Hospital records ☐ Imaging reports

☐ Other specified information: ______________________

Disclosure of Sensitive Information

I understand that my health record may contain sensitive information relating to my condition(s). This includes, but is not limited to information relating to HIV or confirmed diagnosis of or treatment for any other sexually transmitted disease, behavioral or mental health services and treatment for alcohol and drug abuse.

☐ By checking this box, I choose to exclude the above types of information from this disclosure.

Terms and Conditions

- I have the right to revoke this Authorization, in writing, at any time by notifying the Privacy Officer at Activate Healthcare and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that has already been disclosed. To contact the Privacy Officer, please email privacy@activatehealthcare.com.
- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
- I may be responsible for the cost of copying my medical records under state law.
- This Authorization expires one (1) year after the date of signature unless otherwise specified:

______________________________ ______________________________
Signature of Patient or Legal Guardian Signed Date

______________________________ ______________________________ ______________________________
Print Patient's Name Print Legal Guardian's Name (if applicable) Relationship to Patient

*Required information

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Prescription Drug Information

Patient Name: | Date of Birth (mm/dd/yyyy):

A variety of prescription generic drugs are available to you for free at this location. You have the right to choose to fill your prescriptions at the pharmacy of your choice. If you would like to have your prescription sent to a local pharmacy or to a mail order service, simply let the Activate Healthcare team know your pharmacy's contact information. Please initial here to acknowledge your right to choose the pharmacy that will fill your prescriptions.

Patient Signature | Date

Authorized friend/family member(s) that may pick up medications or paper prescriptions:

Print name of authorized person | Print name of authorized person

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