TotalWell Health Clinic
1425 Tuskawilla Road Suite 221, Winter Springs, Fl 32708
Phone Number: 407-775-5315
Email: totalwellhealth@gmail.com
Website: **www.totalwellhealth.com**

PATIENT CONSENT FORM TO RECEIVE MEDICAL CARE AND TREATMENT

I, the undersigned, hereby consent to the provision of medical care and treatment at **TotalWell Health Clinic** under the supervision and direction of the healthcare providers and medical staff at this facility.

By signing this consent form, I acknowledge and agree to the following:

CONSENT TO MEDICAL CARE AND TREATMENT

1. **Medical Services**
   I consent to receiving medical care, including but not limited to diagnostic services, examinations, laboratory tests, prescriptions, procedures, vaccinations, and treatments that my healthcare provider recommends or considers necessary for my condition.

2. **Nature of Treatment**
   I understand that my healthcare provider will explain the purpose, nature, benefits, and risks of the treatments or procedures being proposed. I understand that no guarantees or promises have been made regarding the outcome of any treatment.

3. **Alternative Treatment Options**
   I acknowledge that I have been informed of alternative treatment options, including the option to decline any treatment or procedure. I understand that I may ask questions regarding these alternatives.

4. **Emergency Medical Care**
   In case of an emergency, I consent to receiving emergency medical treatment, as determined by my healthcare provider, to address urgent medical needs. When beyond the scope of care provided by the clinic, I will be informed of this and directed to go to another treatment facility that is appropriate for the level of care needed.

5. **Medications**
   I consent to receiving prescribed medications as needed for my condition and acknowledge the importance of following my healthcare provider’s instructions for medication use.

6. **Refusal of Treatment**
   I understand that I have the right to refuse any treatment, procedure, or diagnostic test at any time. However, I am aware that refusal of certain treatments may adversely affect my health or condition.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. **Sharing of Medical Information**
   I authorize the release of my medical information to other healthcare providers involved in my care, including specialists, pharmacies, or labs, for the purpose of coordinating treatment, ensuring continuity of care, and facilitating any necessary referrals.
2. **Access to Records**
   I understand that my medical records will be maintained in accordance with **HIPAA** (Health Insurance Portability and Accountability Act) regulations to protect the privacy and confidentiality of my health information.

ACKNOWLEDGMENT AND UNDERSTANDING

- I have been given the opportunity to ask questions about my medical care, the proposed treatment plan, and any risks or alternatives.
- I understand that my healthcare providers will explain treatment options and help me make informed decisions about my care.
- I acknowledge that I have been informed of my rights and responsibilities as a patient.

PATIENT'S CONSENT AND SIGNATURE

I, the undersigned patient, hereby consent to receive medical care and treatment at **TotalWell Health Clinic** and authorize the healthcare providers at this facility to provide care as described above. I understand that this consent remains valid for future medical care and treatment unless I revoke it in writing.

- **Patient’s Name (Printed)**: _____
- **Patient’s Signature**: _____
- **Date**: _____

If applicable (for minors or legal guardians):

- **Legal Guardian’s Name (Printed)**: _____
- **Relationship to Patient**: _____
- **Legal Guardian’s Signature**: _____
- **Date**: _____

FOR OFFICE USE ONLY

- **Received By**: _____
- **Date**: _____
- **Provider’s Name**: _____