TotalWell Health Clinic
A MULTISPECIALTY ORGANIZATION WITH A SINGULAR FOCUS: YOU

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Consent for Physician Home Visit

Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____
- **Address:** _____
- **Phone Number:** _____
- **Email (optional):** _____

Consent for Home Visit:

I, the undersigned, hereby give my informed consent for [Physician's Name] and/or their designee to provide medical care to me at my home. I understand the following:

1. **Scope of Care**
   The physician will provide medical services as appropriate based on my current health needs. These services may include physical examinations, diagnostic tests, treatment recommendations, and any necessary follow-up care.
2. **Voluntary Participation**
   I understand that my participation in the home visit is voluntary, and I have the right to withdraw my consent at any time without consequence or loss of medical care.
3. **Confidentiality**
   All personal health information shared during the home visit will be kept confidential, in accordance with HIPAA regulations and other applicable privacy laws.

4. **Risks and Benefits**
   I have been informed of the potential risks and benefits associated with receiving medical care at home, and I acknowledge that there may be limitations compared to receiving care in a clinical or hospital setting. The physician will explain any specific risks involved.
5. **Emergency Care**
   In the event of an emergency requiring immediate medical attention, I will be referred to the nearest medical facility or emergency services.
6. **Transportation and Accessibility**
   I am responsible for ensuring that my home environment is accessible and safe for the physician to provide medical services. If I require transportation to a healthcare facility, I understand that it is my responsibility to arrange for such transportation.
7. **Payment and Insurance**
   I am responsible for ensuring that all payment arrangements are made for the home visit and any services provided, in accordance with my insurance plan or other payment arrangements. I understand that the physician's office will assist in verifying insurance coverage when applicable.

Acknowledgement:

By signing this consent form, I confirm that I have read and understood the information provided above. I have had the opportunity to ask questions regarding the home visit, and all my questions have been answered to my satisfaction. I hereby consent to receive medical care from [Physician’s Name] at my home.

Patient/Guardian Signature: _____

Date: _____

Physician's Signature: _____

Date: _____