KAMERON HEALTH

Kameronhealth.com
(House Calls and TeleHealth)

PH.: 469-634-6690
Fax: 972-433-5038

Provider@Kameronhealth.com

TREATMENT CONSENT

Informed Consent to Treatment

By signing this document, I do hereby voluntarily consent to be treated by Kameron Health PLLC. I understand that I am free to withdraw my consent and discontinue participation at any time.

I have carefully read, or had read to me, all of the information contained in this intake forms and am fully aware of what I am signing.

I have had the opportunity to ask for a more detailed explanation and do not expect my practitioner to anticipate and explain all possible risks and complications of treatment.

I fully understand that there is no implied or stated guarantee of success for the above-mentioned treatments.

I give my permission and consent to treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Full Name_____

Patient Signature_____Date: _____

YOUR RIGHTS AND RESPONSIBILITIES AS A PATIENT

When you receive services from Kameron Health PLLC, you have the right to:

- Receive high-quality service
- Be treated with respect and courtesy
- Have your information kept private and confidential except as described in *privacy statement*
- Be listened to and have staff work with you to make a plan to address your concerns and needs
- Receive service through telehealth.
- Get information and support to help you make decisions to improve your situation.
- Be served without discrimination.
- Discuss your service with staff to identify if it is working for you and express any questions or complaints that you may have.
- Request to stop treatment if you desire so.

This is what we ask from you:

- Treat the staff and others with courtesy and respect
- Let Kameron Health PLLC staff know at least 4 hours (follow up) or 24 hours (initial psychiatric evaluation) before your scheduled appointment time if you cannot come to an appointment.
- Follow the Policy for Late Cancellation and No-Show to scheduled appointments.

Patient Full Name_____

Patient Signature_____Date: _____

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Medication management:

Medications will not be changed or refilled if you miss your follow up appointment or are overdue for your follow up appointment.

NO CONTROLLED MEDICATIONS WILL BE REFILLED WITHOUT BEING SEEN BY THE PRACTITIONER IN A REGULAR APPOINTMENT.

I understand that Kameron Health PLLC is a provider of medical and psychiatric services and I agree to the above and accept financial responsibility for copays and services not covered by insurance. I understand that it is my responsibility to determine the reimbursement, if any, that I will receive from my insurance company and that any claim to my health insurance is my responsibility.

I consent to the filing of my credit/debit card information in my medical record for charges for telemedicine visits, missed appointments and / or phone calls.

Patient Full Name_____

Patient Signature_____Date: _____