CONSENT FORMS

Full Name *

_____

Social Security *

_____

Date of Birth *

_____

Email *

_____

Phone # *

_____

Address: *

_____

Type full name if you are the legal Power of Attorney (POA) or court-appointed guardian authorized to sign on behalf of the member.

_____

CONSENT FOR TREATMENT

I consent to the medical care necessary to treat the condition for which I seek care at Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC, including diagnostic tests and procedures ordered by Integrated Care healthcare providers. Providers may include a Licensed Family Nurse Practitioner, Psychiatric Mental Health Nurse Practitioner, Licensed Lab Technician, Licensed Advanced Practice Registered Nurse (APRN), or a Licensed Physician Assistant, acting within the scope of practice as permitted by Hawai?i Revised Statutes (HRS) Chapters 453 and 457 and in accordance with state law.

CONSENT FOR IN-HOME LAB SERVICES AND PAYMENT AGREEMENT

I authorize Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC to order and perform laboratory tests at my place of residence. I understand that these services may include, but are not limited to, blood draws, urine collection, and other diagnostic tests deemed medically necessary for my care.

I acknowledge that Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC will submit lab orders to an appropriately licensed laboratory provider, certified under Clinical Laboratory Improvement Amendments (CLIA) and recognized by the Hawai?i Department of Health. I also understand the following:

- Some or all of the lab services provided at my residence may not be covered by my health insurance plan, in accordance with HRS § 431 (Insurance Code).
- I am financially responsible for any in-home lab services that are not covered by my insurance.
- I agree to pay Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC for any uncovered services rendered at my residence.

This consent remains in effect until revoked in writing. I understand that I have the right to refuse services at any time, consistent with HRS § 323D (Patient Rights and Responsibilities) and applicable federal law.Use paragraph blocks to write a description, set of instructions, or provide supplemental information for your patients to help complete the form.

Integrated Care LLC – Medical Scribe Consent

By signing below, the undersigned acknowledges and consents to the presence and use of a medical scribe during healthcare visits with Integrated Care LLC. A medical scribe is a trained individual who assists the healthcare provider by accurately documenting medical information in the electronic health record during or after the visit. The scribe's role is limited to documentation and administrative support and does not include providing medical care, clinical advice, diagnosis, or treatment. The undersigned understands that the medical scribe is bound by the same confidentiality and privacy standards as all healthcare team members and is required to comply with HIPAA and all applicable privacy laws. Participation is voluntary, and the undersigned may request that no medical scribe be present at any time without affecting access to care or the quality of services provided. All questions regarding the role of the medical scribe have been answered, and informed consent is given.

Please sign your name below *

Signature

Date

☐ I am the parent/guardian of this patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
If you have questions about this Notice, please contact our Privacy Officer listed below.

Introduction

Your privacy is important to us. This Notice of Privacy Practices ("Notice") explains how Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC ("we," "our," "us") may use and disclose your Protected Health Information ("PHI") for treatment, payment, and health care operations, as well as other purposes allowed or required by law.

PHI includes information that identifies you and relates to your physical or mental health, health care services, or payment for those services. To promote continuity of care, we maintain an integrated electronic medical record system, allowing authorized providers involved in your care access to relevant information.

Who Follows This Notice

This Notice applies to:

- All departments and units within Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC
- All health care professionals authorized to enter information into your record
- All employees, staff, and other authorized personnel with access to your PHI
- Residents, fellows, and students in training programs affiliated with Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC

Our Legal Duties

We are required by law to:

- Maintain records of the care provided to you
- Keep your PHI private
- Notify you of any breaches involving your PHI
- Abide by the terms of this Notice currently in effect
- Provide you a copy of this Notice

We reserve the right to change our privacy practices and update this Notice accordingly. Any revised Notice applies to all PHI we maintain. Updated versions will be available in our office and on our website.

4. How We May Use and Disclose Your PHI

We may use or disclose your PHI in the following ways:

a. Treatment

To provide, coordinate, or manage your health care, such as sharing information with doctors, nurses, or specialists involved in your care.

We do not disclose genetic information without written consent.

b. Payment

To bill and collect payment for services rendered. This may include sharing information with your insurance company for eligibility, coverage, or medical necessity determinations.

c. Health Care Operations

For administrative, management, and quality improvement activities, such as evaluating staff performance or treatment outcomes.

We may remove identifying information to allow for research or analysis purposes.

d. Education and Training

To support medical education for doctors, nurses, and health professionals involved in training programs.

e. Appointment Reminders

To contact you about appointments or provide care-related information.

f. Treatment Alternatives & Health-Related Services

To inform you about alternative treatments, health-related benefits, or services that may be of interest.

g. Research

To use or disclose PHI for research under specific conditions permitted by HIPAA, with appropriate safeguards in place.

h. Reproductive Services

Information related to reproductive procedures may be reported to authorized entities (e.g., CDC, SART) as required by law, with confidentiality protections in place.

Uses and Disclosures Requiring Your Opportunity to Agree or Object

If you do not object, we may share limited information:

- With family, friends, or others involved in your care or payment
- To notify your family of your condition or location

If you are unable to agree or object, disclosures will be made consistent with your prior expressed wishes and best interests.

Uses and Disclosures Permitted or Required by Law Without Authorization

We may disclose your PHI without authorization in the following circumstances:

- When Required by Law – To comply with federal, state, or local laws.
- To Prevent Serious Threats – To prevent a serious threat to health or safety.
- Organ and Tissue Donation – To authorized organizations as permitted by law.
- Government Functions – To military or national security officials when authorized.
- Legal Proceedings – In response to court orders, subpoenas, or other lawful requests.
- Law Enforcement – For law enforcement purposes as required by law.
- Health Oversight – To oversight agencies for audits, investigations, or inspections.
- Coroners, Medical Examiners, and Funeral Directors – For identifying deceased persons or determining causes of death.
- Workers' Compensation – To comply with applicable workers' compensation laws.
- Business Associates – To contracted partners who assist in operations and are bound by confidentiality agreements.
- Public Health Activities – For reporting diseases, injuries, births, deaths, recalls, and suspected abuse or neglect.

Other Uses and Disclosures

Other uses of PHI not covered by this Notice will only occur with your written authorization.

You may revoke your authorization at any time in writing, except where information has already been disclosed.

Certain sensitive categories (e.g., mental health, substance abuse, HIV/AIDS) may require additional written consent per applicable laws.

Your Rights Regarding Your PHI

You have the following rights:

a. Right to Request Restrictions

You may request limitations on how your PHI is used or shared. We are not required to agree unless the restriction applies to services paid out of pocket.

b. Right to Request Confidential Communications

You may request communications through alternate means (e.g., work phone, P.O. Box). We will honor reasonable requests.

c. Right to Inspect and Obtain Copies

You may review and request paper or electronic copies of your PHI. A reasonable fee may apply.

d. Right to Request an Amendment

If your records are incorrect or incomplete, you may request an amendment. If denied, you may submit a written statement of disagreement.

e. Right to an Accounting of Disclosures

You may request a list of disclosures made about you for up to six (6) years (excluding those for treatment, payment, or operations).

f. Right to a Paper Copy of This Notice

You may obtain a printed copy of this Notice at any time.

g. Right to File a Complaint

If you believe your privacy rights were violated, you may file a complaint with Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC or the U.S. Department of Health and Human Services.

We will not retaliate for filing a complaint.

Contact Information:

Privacy Officer – Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC

Address: 99-818 Meaala St, Aiea, Hawaii 96701

Phone: 808-738-7671 | Fax: 689-212-0762 | Email: team@integrated-care.org

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

We will ask you to sign an acknowledgment that you have received this Notice.

If you decline or are unable to sign, we will document our good faith effort to provide you a copy.

I have been presented with a copy of Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC's Notice of Privacy Practices, detailing how my medical information may be used and disclosed as permitted by law. I authorize a copy of this acknowledgment to be used for medical insurance billing and benefits assignment.Use paragraph blocks to write a description, set of instructions, or provide supplemental information for your patients to help complete the form.

Please sign your name below *

Signature

Date

☐ I am the parent/guardian of this patient

Health Insurance
Agreements

I understand that payment is required at the time of service. As a courtesy to our patients, we will file claims for you with the many health plans that Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC participates with. Please note that insurance verification or prior authorization is not a guarantee of payment. If for any reason we are unable to verify insurance eligibility prior to office visit or if the insurance does not provide coverage or fails to pay the treatment amount in full, that I, the patient, am responsible for full payment upon service being rendered. Please note that an estimated patient payment liability is expected at the time services are rendered and this is estimated based on known deductibles, copays, and coinsurance due for your visit. While we may estimate the financial responsibility, it is ultimately the insurance company that makes the final determination regarding eligibility and benefits. Please note that not all procedures may be covered by your insurance company, or may be considered “not medically necessary or cosmetic” by your health plan. Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC will provide patient care based on medical needs and not on patient’s insurance coverage.
Please contact our billing department if you should have any questions or concerns regarding your billing statement at **Team@integrated-care.org** or **(315) 608-0686**. I may submit receipts, invoices, or other documentation to my health insurance company for reimbursement purposes, application towards my deductible, or for other health insurance company reasons that will benefit me.Use paragraph blocks to write a description, set of instructions, or provide supplemental information for your patients to help complete the form.

Radio button * *(select one)*

- ◯ I am knowingly and actively declining to use my health insurance coverage for services received through Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC.
- ◯ I am knowingly and actively choosing to use my health insurance coverage for services received through Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC. I understand that if my insurance company declines payment or does not cover certain services, I am financially responsible for any remaining or non-covered service fees.

Please sign your name below *

Signature _____ Date _____

☐ I am the parent/guardian of this patient

Informed Consent for Telehealth Services

Purpose of Telehealth Services

Telehealth involves using electronic communication technologies (such as video conferencing, phone, or secure messaging) to allow healthcare providers at different locations to deliver clinical care, review charts, prescribe medications, coordinate treatment, refill prescriptions, schedule appointments, and provide patient education.

Telehealth visits through Tebra EHR may include one or more of the following:

- Review of health records, test results, or diagnostic data
- Live two-way audio and video interactions
- Remote prescribing and follow-up
- Health information sharing and patient education

All systems used by Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC incorporate industry-standard network and software security protocols to protect the confidentiality and integrity of your data.

Consent for Telehealth Consultation

I understand that I am voluntarily choosing to participate in telehealth services provided by Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC using Tebra EHR (via Zoom or Doximity). I understand that:

- Potential Benefits include easier access to care, improved continuity of care, and convenience.
- Potential Risks include technical difficulties, interruptions, and unauthorized access despite reasonable security measures.
- Either I or my provider may discontinue a telehealth session at any time if the environment or technology is not adequate for safe care delivery.
- I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

Telehealth Platform Disclosure

Telehealth services are conducted through Tebra EHR. Tebra provides the technology platform to facilitate secure videoconferencing but does not provide medical care or emergency services. Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC and its licensed providers are solely responsible for clinical care delivery.

I will:

- Ensure confidentiality by not sharing my telehealth link with unauthorized individuals.
- Use a secure and private environment to protect my personal health information.
- Contact the clinic at (808) 738-7671 for any technical issues or access problems.

Terms of Consent

Consent to Telehealth Services

I consent to receive healthcare services from Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC via telehealth technologies. My provider will determine whether my clinical needs are appropriate for a telehealth encounter.

Privacy and Security

I understand that Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC complies with federal and state privacy laws and will take all reasonable measures to protect my information.

Technical Issues

I understand technical failures may occur beyond the clinic's control and agree to hold Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC harmless for any delay or loss of data.

Right to Withdraw Consent

I may withdraw consent for telehealth services at any time without affecting my right to future care or treatment.

Alternative Options

In-person services may not be available at Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC. Certain procedures (e.g., lab work, imaging, vital signs) may need to be completed at an external facility as directed by my provider.

No Guarantee of Results

I understand that while telehealth aims to improve access and care quality, results cannot be guaranteed.

Access to Medical Records

I may request copies of my medical records. Reasonable fees may apply for preparation or delivery.

Technical Readiness

I will test my device and internet connection before my scheduled appointment to ensure readiness for my session.

Clinic Contact

I will contact Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC at (808) 738-7671 if I experience technical issues or need support accessing my appointment.

Confidentiality

I understand that sessions will not be recorded and that all information shared is confidential, except where disclosure is required by law.

Licensure

I acknowledge that services are provided by Dr. Raquiel Andersen, DNP, FNP-C, PMHNP-C, and Carissa Bolo, PMHNP-BC, licensed in the State of Hawaii.

Emergencies

I understand that Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC does not provide emergency care. In a medical emergency, I will call 911 or go to the nearest emergency department.

Medication Reactions

I understand it is my responsibility to contact my primary care provider or seek emergency care if I experience an adverse medication reaction.

Communication with Assigned Case Manager and/or Caregiver

If I have an assigned case manager and/or caregiver, I authorize Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC to communicate with them on my behalf if I am unavailable or if additional information needs to be shared to coordinate care, ensure continuity, or support treatment planning.

Patient Consent and Acknowledgment

I have read (or had read to me) this consent form and understand the information contained herein, including the potential risks and benefits of telehealth services. All my questions have been answered to my satisfaction.

By signing below, I voluntarily consent to receive telehealth services from Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC under the terms described above.Use paragraph blocks to write a description, set of instructions, or provide supplemental information for your patients to help complete the form.

Please sign your name below *

Signature

Date

☐ I am the parent/guardian of this patient

Email–SMS Informed Consent

To communicate with you by email or Short Message Service (SMS, sometimes referred to as “texting”), we would like to inform you about risks to confidentiality that may arise when communicating via these methods. You always have the option of communicating via Spruce or the Electronic Health Record Client Portal, both of which are secure and HIPAA-compliant.

Agreements

1. I understand that communication with Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC — via email or SMS — may be initiated by me under certain circumstances, most notably, for convenience.
2. I understand that email and SMS messages may not be encrypted and, therefore, may not be considered secure. There is a potential that those messages could be read by someone for whom the message is not intended. For this reason, Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC cannot guarantee that email and SMS messages are secure.
3. By using email or SMS when communicating with my provider at Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC, I am giving permission for that provider to reply, and acknowledging that Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC cannot guarantee security of emails or SMS messages, I agree that Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC shall not be liable for a breach of confidentiality resulting from an electronic security issue.
4. I understand that my provider will use their best professional judgment to limit email and SMS messages to brief inquiries or responses regarding scheduling or coordination. At times, my provider may send me information about resources via email or SMS that can enhance my treatment and I consent to receive this information.
5. I understand that email and SMS are not appropriate for time-sensitive matters and agree to use the Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC Electronic Health Record Client Portal (both secure and HIPAA-compliant) to request scheduling changes or make inquiries for other time-sensitive matters.
6. I understand that elements of email and SMS messages may be input into my health record (“chart”) and that those elements would then be accessible to anyone who has been given access to those records by Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC.
7. If I have an assigned case manager and/or caregiver, I authorize Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC to communicate with them on my behalf by phone or SMS for purposes related to medication refills, critical notes, or urgent clinical matters when necessary for continuity of care. All personally identifiable information (PII) will only be discussed and shared through proper HIPAA-compliant channels.

I understand and agree to the statements above, and my signature below indicates that, should I initiate using these methods, I consent to email and SMS communication with Integrated Care LLC & Subsidiary LLC Integrated Care Mental Health LLC.Use paragraph blocks to write a description, set of instructions, or provide supplemental information for your patients to help complete the form.

If we need to contact you regarding any future appointments or test results, may we leave a message? * *(select one)*

- ◯ YES
- ◯ NO

Would you like us to e-mail you patient education handouts rather than give you hard copies? *(select one)*

- ◯ YES
- ◯ NO

Please sign your name below *

Signature _____ Date _____

☐ I am the parent/guardian of this patient

Patient Portal Access Authorization Form

I hereby authorize the following individual to access my patient portal and to receive all visit notes, encounter details, and medical records on my behalf.

I understand that by granting this access, the authorized individual will have full access to my medical information, including but not limited to:

- Visit summaries and encounter notes
- Laboratory and imaging results
- Medication lists
- Diagnoses and treatment plans
- Any other protected health information (PHI) contained within the patient portal

I acknowledge that I may revoke this authorization at any time by providing written notice to the clinic. This authorization will remain in effect until revoked in writing.

Authorized Caregiver Name

_____

Please sign your name below *

_____ _____

Signature Date

☐ I am the parent/guardian of this patient

Integrated Care LLC – Complex Care Management and Behavioral Health Case Management Consent

By signing below, the undersigned authorizes enrollment in the Complex Care Management program and, when clinically indicated, Behavioral Health Case Management services provided by Integrated Care LLC. These services are intended for individuals with multiple chronic or complex medical conditions and/or behavioral health conditions that require ongoing coordination, monitoring, and structured support. Services may include development and maintenance of a comprehensive care plan, coordination with primary care, specialists, behavioral health providers, and community resources, medication review, use of validated screening or assessment tools for behavioral health conditions, health monitoring, and non–face-to-face communication such as telephone calls, secure electronic messaging, and care coordination activities performed outside of routine in-person visits. Behavioral health case management services may be provided under CPT 99484 when requirements are met and are designed to support conditions such as depression, anxiety, or other behavioral health concerns within an integrated care model; these services are not psychotherapy and do not replace psychiatric or counseling visits. Services may be provided by a nurse practitioner, behavioral health care manager, or qualified clinical staff under appropriate supervision. Participation is voluntary and does not replace office visits, urgent care, emergency services, or hospital care. The undersigned understands that these services may be provided on a monthly basis when medically appropriate, that relevant health information may be shared among members of the care team as permitted by law, and that insurance cost-sharing such as copayments or coinsurance may apply depending on individual coverage. Consent may be withdrawn at any time by providing verbal or written notice, and withdrawal will not affect access to other services provided by Integrated Care LLC. All questions have been answered, and informed consent is given.

Do you consent to CCM and/or BHI Management should it be deemed necessary?

☐ Yes

☐ No

Please sign your name below *

Signature

Date

☐ I am the parent/guardian of this patient