CORNERSTONE HOUSE CALLS

CONSENT FOR TREATMENT BY CORNERSTONE HOUSE CALLS

By signing this consent, I confirm that I request, authorize and consent to medical treatment and care by Cornerstone House Calls, their Physicians, Nurse Practitioners, Contractors and other health care providers (collectively called "Cornerstone").

I also consent to treatment and care by physicians and health care providers who are not employees or agents of Cornerstone but are authorized by Cornerstone to provide treatment and care to me as a patient of Cornerstone. I am aware that Cornerstone providers may be independent contractors of Cornerstone, and they provide services to the Cornerstone's patients in accordance with their professional judgment. I understand that my care team at Cornerstone may include resident physicians, nurse practitioners, physician assistants, medical assistants, registered nurses, social workers, administrative staff, students and/or other trainees.

I understand that my care is directed by Cornerstone and that other personnel render care and services to me (the patient) according to the Cornerstone's instructions.

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostic procedures. I authorize Cornerstone and its extended providers to dispose of the bodily fluids.

I have been informed and understand that an HIV (human immunodeficiency virus – AIDS) test may be performed on me without my consent if a health professional or Cornerstone provider or First Responder sustains an exposure to my blood or other body fluid.

A drug screen by blood or urine sample may be obtained with verbal consent for purposes of verifying compliance with medication regimens or when abuse or misuse is suspected or when signs or symptoms of toxicity exist.

I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition, such as laboratory testing, routine diagnostics, radiology and laboratory procedures, administration of routine drugs, biological and other therapeutics, ad routine medical nursing care. Some or all of these services may be provided by third parties upon instruction by Cornerstone House Calls, and will bill my insurance separately.

I am aware that the practice of medicine (including surgery) is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, procedures, or effectiveness of medications. Being seen by Cornerstone does not guarantee that any provider will prescribe any medications.

I authorize Cornerstone to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health, and in accordance with any existing DNR Orders, if provided to Cornerstone.

Signature:_____ Signature: _____

Print Name:_____ Print Name: _____

Date:_____ Date: _____

(Patient) *(Patient's Representative or Caregiver)*

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing this acknowledgement, I acknowledge that I have been offered and/or received the Cornerstone House Calls Notice of Privacy Practices, and I have had an opportunity to ask questions.

Cornerstone's Notice of Privacy Practices is a complete description of my privacy rights as a patient of Cornerstone.

Cornerstone's Notice of Privacy Practices provides information about how protected health information about me (the patient) – including information about human immunodeficiency virus (HIV), AIDS-related complex (ATC) and acquired immunordeficiency (AIDS); including substance abuse treatment records protected under the regulation 42 Part 2, in the Code of Federal Regulations (if any); and psychological and social services records, including communication made to me by a social worker or psychologist (if any) may be disclosed.

I have been offered an opportunity to review the Cornerstone's Notice of Privacy Practices before signing this consent.

I further understand that Cornerstone reserves the right to change its notice and practices, in accordance with Section 164.520 of the Code of Federal Regulation.

I understand that the terms of the Notice may change and I may obtain a revised copy by contacting Cornerstone's office.

Signature:_____ Signature:_____

Print Name: _____ Print Name: _____

Date: _____ Date: _____

(Patient) *(Patient's Representative or Caregiver)*