Nevada Health Centers, Inc.
PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form. Changes or alterations to this form are not binding on Nevada Health Centers and/or its affiliated facilities (each and all of them referred to as "NVHC" in this form).

Consent to Healthcare Services: I am requesting that healthcare services be provided to me (or my minor child or the patient named below) at NVHC. I voluntarily consent to all medical treatment, dental treatment, behavioral health treatment, and healthcare-related services that the caregivers at NVHC consider to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services, including HIV testing. If I want any HIV testing to be performed anonymously, I will tell my NVHC caregiver.

I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations. I understand that NVHC is a teaching facility and that residents and students (under the direct guidance of my healthcare provider or clinical staff) may observe and /or participate in my care, during the course of my visit.

Electronic Health Records Portal: I understand that NVHC provides an electronic patient portal where I can access certain aspects of my health record and communicate with my care team. With the implementation of the federal law 21st Century Cures Act, NVHC is required to release the results of labs and diagnostic studies immediately with very few exceptions. As a result, I may see these reports in the portal prior to the provider reviewing them. If I have any questions about the results, I understand I need to contact my provider.

I also understand that by participating in an electronic patient portal as either a Parent or Guardian of a minor ages 0–11, that I will have proxy access for those minors. Due to Federal and State confidentiality laws specific to teen patients (ages 12–17), there are certain types of medical information that cannot be viewed by the Parent or Guardian without the consent of the minor patient. Subsequently, I understand that my portal access for my minor child (ages 12–17) will automatically change to Proxy-Teen Access which will result in limited access for the proxy user. At the time the minor reaches their 18th birthday the proxy user will lose access to that chart.

Telemedicine: I understand that NVHC may provide certain services by remote telehealth technology. Telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine and, as always, my insurance carrier will have access to my medical records for quality review/ audit. I understand that I will be responsible for any copayments or coinsurances that may apply to my telemedicine visit.

Clinical Pharmacy Services: I understand that NVHC may provide certain clinical pharmacy services. Such clinical pharmacy services involve a clinical pharmacist working in collaboration with my Primary Care Provider. During these appointments, the clinical pharmacist may initiate, modify, or discontinue medications pursuant to a collaborative practice agreement. I understand that the clinical pharmacist is not a physician, advanced practice registered nurse or physician assistant and may not diagnose. Furthermore, I understand the clinical pharmacist has the right not to answer questions or perform services outside the pharmacist's scope of practice.

Uses and Disclosures of Health Information: I have received Nevada Health Centers' Notice of Privacy Practices. The Notice of Privacy Practices explains how Nevada Health Centers may use and disclose confidential health information that identifies me (or the below-named patient). I consent to let Nevada Health Centers use and disclose health information about me (or the below-named patient) as described in the Notice of Privacy Practices.

In doing so I consent to the release of my (or the below-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by NVHC, its or billing agents, collection agents, attorneys, consultants and/or other agents that represent NVHC or provide assistance to NVHC for the purposes of securing

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payment from all parties who are potentially liable for payment for my (or the below-named patient's) healthcare, including for substance abuse, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that NVHC has already relied on my consent.

I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to NVHC on this form or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from NVHC and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services from NVHC or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

I hereby consent and grant to NVHC the right and authority to photograph and/or record me, my image and voice, which could occur in connection with my diagnosis and treatment, and I agree that upon creation such images and/or recordings are owned by NVHC. I understand that I have the right to request cessation of recording or filming at any time and I agree to release and forever discharge NVHC, its agents, officers, and employees from any and all claims arising out of or in connection with the use of these images and/or recordings including, but not limited to, any claims for invasion of privacy, right to publicity or defamation.

Use of electronic devices (i.e., phones, tablets, etc.) while on premises: We take patient and staff privacy seriously. While you are at a Nevada Health Centers facility, you agree to refrain from using your mobile phone or device in such a way that it invades the privacy or compromises the safety of those around you. This includes taking or making photos or videos of people or your surroundings, creating audio recordings, or otherwise using your mobile device in such a way that represents a distraction or safety concern to your care team, other staff members, or patients. We realize that there may be circumstances in which you must use your mobile device, for example, taking an emergency call, etc.; however, while you are with us for your appointment, you will make reasonable efforts to limit its use. This includes refraining from creating social media posts on SnapChat, Tik Tok, etc., or generally taking photos or videos while onsite at your appointment.

Valuables/Limitation of Liability: I understand that I should not bring valuables (cell phone, electronic devices, medical equipment, jewelry, money, irreplaceable documents, etc.) with me to NVHC. If I choose to bring valuables to NVHC, I AGREE THAT NVHC SHALL NOT BE RESPONSIBLE FOR VALUABLES.

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Printed Name of Patient	**Patient's Date of Birth**

By signing below, I am indicating that I have reviewed and acknowledge and consent to the terms described above:

In Person Consent

Signature of Patient or Responsible Party	Date/Time
Printed Name of Responsible Party, if not the patient	Responsible Party's Relationship to Patient
Phone Number(s)	

OR

Telephone Consent

Printed Name of Individual Providing Telephone Consent	Date/Time
Printed Name of Responsible Party, if not the patient	Responsible Party's Relationship to Patient
Phone Number(s)	