Lemon-AID
Medical Management

CONSENT TO TREAT & ELECTRONIC CONSENT

Welcome to Lemon-AID Medical Management; our main goal is to provide quality care for our patients. The doctors and staff will strive to perform the necessary and reasonable services required for your well-being and care. You may find a copy of our Lemon-AID Medical Management Welcome Form and the Joint Notice of Privacy Practices Form on our website and patient portal. If you would prefer a paper copy for your records, please request this at the time of registration.

This form covers your care. Insurance, billing, and payment — including the assignment of your insurance benefits, the release of your information to your health plan, and your financial responsibility for charges — are covered by a separate form, the Authorization to Release Billing Information & Assignment of Benefits.

ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING OF OUR LEMON-AID MEDICAL MANAGEMENT WELCOME FORM

Please sign to confirm that you have received, read, and understood the Lemon-AID Medical Management Welcome Form.

ACKNOWLEDGEMENT OF RECEIPT OF THE JOINT NOTICE OF PRIVACY PRACTICES

You have been given the Joint Notice of Privacy Practices ("Notice") for Lemon-AID Medical Management and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of Lemon-AID Medical Management and its Physicians with respect to health information created for services. Please sign that you have received, read, and understand this Notice.

CONSENT TO TREAT

I voluntarily authorize the physicians, advanced practice providers, nurses, technicians, and other clinical and administrative staff of Lemon-AID Medical Management, and those acting under their direction or by their referral, to perform examinations, evaluations, diagnostic and screening tests (including routine laboratory and blood testing), immunizations, and any other routine care, treatment, or services deemed necessary or advisable for the diagnosis and treatment of my medical conditions, now and on all future dates of service.

I understand this is a general consent for routine care and that it does not replace the separate, procedure-specific informed consent that I will provide before any surgical, invasive, anesthetic, or other procedure requiring specific disclosure of risks under Texas law.

CONSENT TO TREATMENT BY A PHYSICIAN ASSISTANT OR NURSE PRACTITIONER

Care at Lemon-AID Medical Management may be provided by physician assistants (PAs) and advanced practice registered nurses, including nurse practitioners (NPs), as well as by physicians. Physician assistants and nurse practitioners are licensed health care professionals who have completed graduate-level education and supervised clinical training and who hold a license issued by the State of Texas.

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I understand that a physician assistant or nurse practitioner may take my medical history, perform physical examinations, order and interpret laboratory and imaging studies, diagnose and treat medical conditions, prescribe medications within the limits of their prescriptive authority, perform procedures within their training and scope of practice, refer me to specialists, and provide my follow-up care.

PHYSICIAN INVOLVEMENT. Physician assistants and nurse practitioners at Lemon-AID Medical Management practice under the delegation and supervision of a supervising or collaborating physician, in accordance with Texas law and a written agreement between them. A physician is available for consultation, and my care may be reviewed by that physician. I understand that a physician will not necessarily see me in person at every visit, and that a physician assistant or nurse practitioner may be the provider who evaluates and treats me.

MY RIGHT TO KNOW WHO IS TREATING ME. I have the right to be told the name and professional title of each person involved in my care, and to ask about their license, training, and role. Every provider at Lemon-AID Medical Management will identify themselves and their license type to me.

MY RIGHT TO REQUEST A PHYSICIAN. I may ask at any time to be seen by a physician instead of, or in addition to, a physician assistant or nurse practitioner. Making that request will not affect the quality of my care or my standing as a patient, although it may affect how soon an appointment is available.

I consent to evaluation, treatment, and follow-up care by the physician assistants and advanced practice registered nurses, including nurse practitioners, employed by or under contract with Lemon-AID Medical Management, as well as by its physicians, on this and all future dates of service.

Patient Initials: _____

CONTINUING EFFECT; TERM AND REVOCATION. I intend this document to be a general, continuing consent. It becomes effective on the date signed below and remains in effect for all care I receive from Lemon-AID Medical Management, its physicians, advanced practice providers, employees, contractors, affiliates, and successor entities, at any of its locations, on this and all future dates of service, until I revoke it. This consent does not expire with the passage of time and does not require annual renewal.

I may revoke this consent, in whole or in part, at any time by delivering a signed, written revocation to Lemon-AID Medical Management. Revocation is effective only when Lemon-AID Medical Management receives it and applies only prospectively; it does not affect any action taken, care provided, disclosure made, or charge incurred before Lemon-AID Medical Management received the revocation. Revoking my consent to treat may mean that Lemon-AID Medical Management can no longer provide care to me.

A photocopy, facsimile, scanned image, or electronic copy of this document is as valid as the original. I agree that my electronic or digital signature has the same force and effect as my handwritten signature.

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Patient Initials: _____

NO GUARANTEE OF RESULTS

I understand that the practice of medicine is not an exact science and that no one has guaranteed, warranted, or assured me of the results or outcome of any examination, test, treatment, or care provided to me. I understand that unfavorable results may occur even when care is provided appropriately.

RIGHT TO REFUSE OR WITHDRAW

I understand that I have the right to ask questions, to request additional information, to refuse any recommended test, treatment, or medication, and to withdraw my consent at any time. I understand that refusing or discontinuing recommended care may adversely affect my health, and I accept responsibility for the consequences of any such refusal. If I leave against medical advice or decline recommended follow-up, I understand that Lemon-AID Medical Management is not responsible for the outcome.

TEACHING, STUDENTS, AND OBSERVERS

I consent to the presence and participation of residents, fellows, medical and nursing students, scribes, and other trainees or observers in my care, under the supervision of my treating provider. I understand I may ask that any observer not be present.

PHOTOGRAPHY AND IMAGING

I consent to photographs, videos, and other images being taken of me or of my condition when used for my diagnosis, treatment, or medical record. Images will not be used for marketing, publication, or any purpose outside my care without my separate written authorization.

SPECIMENS AND TESTING

I consent to the collection, handling, testing, storage, and disposal of blood, tissue, and other specimens obtained from me in the course of my care, in accordance with applicable law and standard laboratory practice.

TELEHEALTH

I consent to receive care from Lemon-AID Medical Management by telemedicine or telehealth, including audio-only and audio-video visits. I understand the benefits and limitations of telehealth, including that a remote evaluation may not be equivalent to an in-person examination, that technology may fail, and that my provider may determine an in-person visit is required. I understand that this telehealth consent is ongoing and applies to all future telehealth encounters until revoked.

ELECTRONIC COMMUNICATION CONSENT

I understand and agree that Lemon-AID Medical Management may contact me using automated calls, emails, portal messages, and text messages (together “Electronic Communications”) sent to my landline, cellular numbers, or e-mail indicated on my Patient Information Form.

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Lemon-AID Medical Management may utilize Electronic Communications to/of/for:

- Notices in the Patient Portal, preventive care, test results, treatment recommendations, and outstanding balances.
- Scheduled appointments.
- Communicate with me about my treatment, care coordination, and case management.
- Other Lemon-AID Medical Management communications.

I understand that I voluntarily consent to receive automated Electronic Communications by providing my phone number and e-mail address. I understand that my telephone service provider(s) may charge me for such calls and that an automated dialing system may generate them. Lemon-AID Medical Management will not charge you for these communications. I understand that electronic communication carries risks. Lemon-AID Medical Management will utilize secure encryption methods to minimize risk.

I understand that I may revoke this consent to receive automated Electronic Communications at any time by any reasonable means, including in writing, verbally, by replying STOP to a text message, or by using the opt-out mechanism in an e-mail. Revoking this consent does not revoke my consent to treatment or any other section of this document, and does not revoke the separate Authorization to Release Billing Information & Assignment of Benefits.

MARKETING COMMUNICATIONS (OPTIONAL — SEPARATE AUTHORIZATION)

This authorization is optional. Treatment, payment, enrollment, and eligibility for benefits do not depend on whether I sign it, and declining will not affect my care.

I authorize Lemon-AID Medical Management to use my contact information to send me marketing communications about new services, programs, and offerings. I understand that if Lemon-AID Medical Management receives payment from a third party in exchange for making these communications, that fact will be disclosed to me. This authorization expires when I am no longer a patient of Lemon-AID Medical Management or upon my earlier revocation.

_____ I AGREE to receive marketing communications.

_____ I DECLINE marketing communications.

Patient Initials: _____

THIRD-PARTY VENDORS

I understand that Lemon-AID Medical Management works with third-party vendors to optimize my experience with Lemon-AID Medical Management and within the health care services. Many of these third-party vendors need access to my personal information, including but not limited to my first and last name, gender, date of birth, ZIP code, address, and other health-related information to enhance the continuity of my care. I understand that the third-party vendors who ask for my protected health information ("PHI") are legally obligated to abide by the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") and are legally and contractually obligated to maintain the security and confidentiality of my information. I understand that these disclosures are made in connection with my treatment and with the health care operations of

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Lemon-AID Medical Management, as described in the Joint Notice of Privacy Practices, and that my signature on this document acknowledges and consents to them. I understand that Lemon-AID Medical Management will obtain my separate written authorization before disclosing my protected health information to any third party for marketing purposes or in exchange for remuneration, as required by law.

AUTHORITY TO SIGN. If I am signing on behalf of the patient, I certify that I am the patient's parent, legal guardian, managing conservator, agent under a medical power of attorney, or other person authorized under Texas law (including Texas Family Code Chapter 32) to consent to the patient's care, and that I will promptly notify Lemon-AID Medical Management if that authority changes or ends. I understand that a minor in Texas is a person under 18 who has never been married and has never had the disabilities of minority removed by a court, and that Texas law permits certain minors to consent to their own care in limited circumstances.

LANGUAGE AND UNDERSTANDING. I have received this document in a language I understand, or an interpreter was offered to me and I have had the opportunity to ask questions. All of my questions have been answered to my satisfaction.

SEVERABILITY. If any part of this document is found to be invalid or unenforceable, the remaining parts remain in full force and effect. This document is governed by the laws of the State of Texas.

My signature below acknowledges that I have read and understand the information in this document, that I am signing it voluntarily, and that I intend it to remain in effect for all future care until I revoke it in writing.

If signed by someone other than the patient, complete the following:

Relationship to patient: _____

Basis of authority (check one):

_____ Parent

_____ Court-appointed guardian or managing conservator (documentation provided)

_____ Grandparent, adult sibling, or adult aunt/uncle of a minor patient

_____ Adult with actual care, control, and possession of the patient and written authorization to consent

By signing, I represent that I have legal authority to consent to this patient's care and that, if I am relying on a relationship listed in Texas Family Code §32.001, the person with the primary right to consent could not be contacted and has not given notice objecting to this treatment. I agree to notify Lemon-AID Medical Management immediately if my authority to consent changes or terminates.

SCOPE OF THIS SIGNATURE. My single signature below applies to this entire document and to each of its sections, including: acknowledgement of receipt and understanding of the Welcome Form; acknowledgement of receipt of the Joint Notice of Privacy Practices; the Consent to Treat; consent to treatment by a physician assistant or nurse practitioner; continuing effect, term, and revocation;

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no guarantee of results; my right to refuse or withdraw care; teaching, students, and observers; photography and imaging; specimens and testing; telehealth; the Electronic Communication Consent; third-party vendors; authority to sign; language and understanding; and severability. I do not need to sign or initial each section separately for that section to be effective. The only exceptions are the optional authorizations — Marketing Communications and Permission to Verbally Discuss Medical Information — which take effect only as I have separately indicated by checkbox or initials, and any section that expressly requires my separate initials. I intend this signature to have the same force and effect for every section as if I had signed each one individually, and to remain in effect for all future dates of service until I revoke it in writing.

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Guardian Name	Guardian Signature	Date

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PERMISSION TO VERBALLY DISCUSS MEDICAL INFORMATION (OPTIONAL)

This consent allows Lemon-AID Medical Management to verbally discuss your medical and sensitive information with the person(s) named below.

I hereby authorize Lemon-AID Medical Management to verbally discuss information about me with:

Name	Relationship	Phone number

This authorization is effective immediately and expires upon the earlier of (a) my written revocation, or (b) the termination of my treatment relationship with Lemon-AID Medical Management. I understand that HIPAA requires this authorization to state an expiration date or event, and that I have chosen a continuing authorization tied to these events rather than a fixed date.

I may revoke this authorization at any time by delivering a signed, written revocation to Lemon-AID Medical Management. Revocation is effective when received and does not apply to disclosures already made in reliance on this authorization.

I understand that Lemon-AID Medical Management may not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I specifically authorize the disclosure of information relating to HIV and AIDS test results and diagnosis, and mental health information (excluding psychotherapy notes), to the person(s) named above. I understand that under Texas Health and Safety Code § 81.103, disclosure of HIV-related information requires my written, signed authorization identifying the person or class of persons receiving it, and that the persons named above are that class.

I understand that information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by HIPAA.

Permission for further use or disclosure of your medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

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CERTIFICATION AND SIGNATURE

I hereby certify that I have read the above Consent to Treat & Electronic Consent form, initialed each section as applicable, and hereby provide my consent. I understand that this consent remains in effect for all future dates of service until I revoke it in writing.

Name of Patient (Printed) _____

Signature _____

Date _____

Cellular Number _____

E-mail _____

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