

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND CONSENT FOR TREATMENT



Patient Name: _____

DOB (Date of Birth): _____

Please read this form carefully before signing to ensure you understand and agree to them. Ask a staff member if you have any questions.

RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Federal law (HIPAA) requires this Practice to provide patients with a Notice of Privacy Practices (NPP) describing how your protected health information may be used and disclosed, and your rights regarding that information.

I have received a copy the Notice of Privacy Practices and understand I may request an additional copy of the Notice of Privacy Practices at any time or go to www.arroyovistafamilymedicine.com. I understand that the Practice may use or disclose my health information for treatment, payment, and healthcare operations as described in the NPP, and that I have the right to request restrictions, access my records, and file a complaint with the U.S. Department of Health and Human Services if I believe my privacy rights have been violated.

LANGUAGE ACCESS / INTERPRETER SERVICES

Arroyo Vista Family Medicine provides interpreter services in English and Spanish at no cost to me. If I require assistance communicating in either language, I may notify a staff member so that my care is provided in my preferred language. I have the right to receive information and participate in my care in a language I understand.

NOTICE OF NOTIFIABLE CONDITIONS

As outlined in the Notice of Privacy Practices mentioned above, I understand there are certain instances where the Clinic may disclose my information as required by the law without my written authorization. I understand that if I am diagnosed with or suspected of having a Notifiable Condition listed by the Texas Department of State Health Services (DSHS), the clinic is required by law to inform public health officials to help prevent the spread of illness.

AUTHORIZATION FOR MEDICAL TREATMENT

I, the undersigned, hereby voluntarily consent to and authorize the physicians, advanced practice practitioners, nurses, medical assistants, and other healthcare personnel at Samuel Landero MD PA doing business as Arroyo Vista Family Medicine to perform examinations, diagnostic tests, treatments, and procedures that may be recommended or deemed necessary for the care of the patient named above. This consent is general in nature and does not replace specific informed consent that may be required for surgical procedures, invasive tests, or other significant interventions. For such procedures, I will be given additional information and asked to sign a separate consent document.

TREATMENT BY ADVANCED PRACTICE PRACTITIONERS

This Practice employs or contracts with Advanced Practice Practitioners (APPs), including:

Physician Associates (PAs): Licensed under the Texas Medical Board, authorized to practice medicine under physician supervision or collaboration as required by Texas law.

Nurse Practitioners (NPs): Licensed as Advanced Practice Registered Nurses (APRNs) under the Texas Board of Nursing, with prescriptive authority delegated by a collaborating physician as required by Texas law.

I understand and consent that my care may be provided, in whole or in part, by an APP. I acknowledge that APPs practice under the oversight of a licensed physician and are qualified healthcare providers. The use of APPs allows our practice to offer greater appointment availability, including same-day appointments, so that patients can be seen in a timely manner.

I have the right to request to be seen by a physician, and the practice will make reasonable efforts to accommodate such requests, though appointment availability may vary.

RIGHT TO REFUSE TREATMENT

I understand I have the right to refuse any examination, test, treatment, or procedure and to withdraw this consent at any time, except to the extent that action has already been taken. I acknowledge that refusal of recommended treatment may have consequences for my health.

EMERGENCY TREATMENT AUTHORIZATION

In the event that I am unable to provide consent due to a medical emergency, unconsciousness, incapacity, or other condition preventing communication, I authorize the providers at Arroyo Vista Family Medicine to render such emergency examination, treatment, or procedures as are deemed medically necessary to preserve my health and life. This authorization applies until I regain capacity or a legally authorized representative is available to provide consent.

CONSENT FOR TREATMENT OF MINOR PATIENTS (Patients under 18 years of age)

Under Texas law, a parent, managing conservator, or legal guardian must consent to medical treatment for a minor child. By signing this form, I represent and warrant that I have legal authority to consent to treatment on behalf of the minor patient named above. I understand there are Texas statutory exceptions (Texas Family Code, Chapter 32) allowing certain minors to consent to their own medical treatment without parental consent, including when the minor:

- Is or has been married;
- Is on active duty with the U.S. Armed Forces;
- Is at least 16 years of age, lives apart from parents or guardians, and is managing their own financial affairs;
- Consents to treatment for drug or alcohol addiction;
- Consents to treatment for a communicable disease as permitted by law; or
- Has been granted the right to consent by a court order.

PHOTOGRAPHS AND CLINICAL DOCUMENTATION

I consent to photographs, videos, or other clinical documentation being taken solely for medical record purposes. Any use beyond the medical record (e.g., education, research, or publication) will require a separate written consent.

TELEMEDICINE / E-VISIT SERVICES (AVAILABLE IN-STATE ONLY)

Telemedicine services are health care services delivered by physicians and health professionals to patients located at a different physical location using telecommunications or other information technology.

- I understand Telemedicine / E-Visit Services are only available to me if I am physically in the state of Texas
- I understand the same standard of care applies to health care services delivered via telemedicine as applies to an in-person visit. This includes paying any co-pays, co-insurance, or other insurance-required payments
- If it is determined the telecommunications or information technology is not adequate, the visit may be discontinued
- I have the right to refuse to participate or decide to stop participating in a telemedicine visit at any time
- Information shared using telecommunications may include patient medical records, medical images, medical audio or video files, two-way audio and video, and output data from medical devices. The systems used by the center to transmit and receive this information will incorporate network and software security protocols intended to protect the confidentiality of the patient’s identify and information
- I understand there are certain hazards and risk connected with all forms of treatment, regardless of the medium used, and my consent is given knowing potential risk using technology, including service interruptions, interception and technical difficulties.

STANDARD OF CARE AND ETHICAL PRACTICE WITH NO GUARANTEE OF RESULTS

Samuel Landero MD PA doing business as Arroyo Vista Family Medicine and its providers are committed to delivering care that meets accepted medical standards and is guided by ethical principles of honesty, respect, and patient-centered practice. We will always recommend and provide treatment based on what is clinically appropriate for each individual patient. No guarantee or assurance has been made to me regarding the results of any examination, treatment, or procedure performed at this practice. While medicine is not an exact science and individual outcomes vary, our patients can be confident that their care will be thoughtful, evidence-based, and delivered with integrity.

ACKNOWLEDGMENT AND SIGNATURE

By signing below, I confirm that I have read and understood this Receipt of Notice of Privacy Practices and Consent for Treatment, have had the opportunity to ask questions, and agree to its terms. If signing on behalf of a minor or other patient, I represent that I have the legal authority to do so. A photocopy of this document is as valid as the original.

Signature of Patient, Parent, or Legal Guardian

Date

Witness (Staff) Signature

Date